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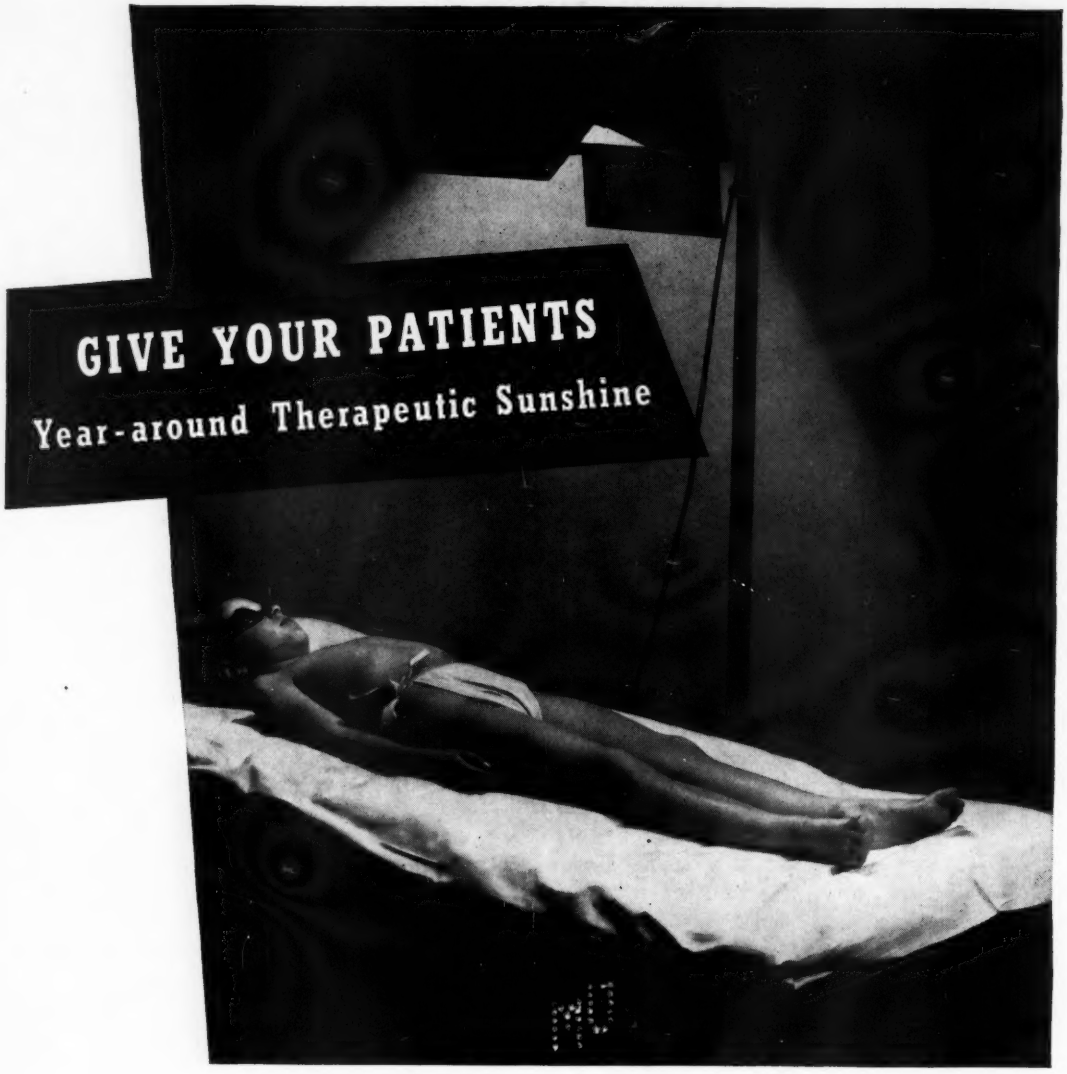

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HOSPITAL MANAGEMENT

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(Cover photograph, Hackley Hospital, Muskegon, Michigan)

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"To Talk of Many Things . . . ."

Signatories to Consent to Operate

A hospital superintendent asks as to the proper signatories to consent to operate, the patient being competent and of legal age:

1. The patient must sign.
2. The husband does not have the right to sign for the wife nor the wife for the husband.
3. Sterilization is authorized in some states and the signatures of both husband and wife are required. If sterilization is likely to be the result of an operation, this fact should be explained to both husband and wife and both should sign the consent.
4. In case of incomplete abortion the signature of the patient is sufficient, but she should sign a statement exonerating the surgeon, the hospital and all those connected with it.
5. I am not aware of any legal decision regarding therapeutic abortion but, since this involves destruction of a child in whom both husband and wife are interested, I believe that both should sign the consent. It is presupposed that no therapeutic abortion will be performed without at least one senior consultant who agrees with the surgeon as to the necessity for the abortion.

Two Contrasting Books

I have recently read two books which, because of the contrast, have greatly impressed me. One is "The Citadel" by A. J. Cronin; the other, "Life and Death" by Antonio Majocci. Both concern themselves primarily with physicians and the practice of medicine, but the hospital is involved to such an extent that their influence cannot be disregarded.

"The Citadel" has three central thoughts: the evils of commercial medicine; the poor care given patients under contract practice or state medicine, whichever it is, as illustrated by the panel system of England, and the ideal of a group practice in which the members are in harmony and are giving first consideration to the good of the patient.

As regards commercialism, why all the furor? It is universally recognized as an unmitigated evil which exists, has always existed and will continue to be the concern of those conscientiously devoting themselves to the care of the sick. It is found in every profession and trade and will continue to flourish so long as men are men with financial ambitions. Organized medicine has always fought against commercialism, with varying degrees of success, and will continue to do so unless regimentation develops to so great an extent as to destroy all ideals and initiative.

The panel system was foisted on the physicians of England by Lloyd George, without consulting them and against their wishes. The resulting lack of proper care of the patients is well known and organized medicine in this country has consistently opposed any form of state medicine or contract practice. Up to date the fight has been reasonably successful but the tendency toward socialism which appears to be increasing requires that developments be carefully watched.

Group practice has been tried many times in this country with rather diverse results from the point of view of the care of the patient. If the group is made up of ethical, conscientious physicians as described in "The Citadel", it is an unadulterated blessing to the patient, but unfortunately all groups are not of this type. In some cases group practice has resulted in the worst form of commercialism and the patient has been financially exploited, not medically treated.

The effect of this book will depend entirely on the mental reaction of the reader. The thoughtful person will recognize the evils depicted and will become an ally of organized medicine in combating them. But the reader who reads only for the story will see little but the evils of the undesirable class of physicians and will lose some of his faith in the effectiveness and honesty of medical care. Frankly, I am afraid the latter class will predominate and that the general effect will be harmful.

"Life and Death" is quite the opposite type of book. It is the autobiography of a Milanese surgeon who started his professional education without funds or influence and by sheer grit succeeded in overcoming all obstacles. Throughout his whole life he maintained the highest standards of ethics and ideals and finally became a great surgeon. Perhaps he never attained financial security, but certainly he reached the pinnacle of success professionally and never at any time lost sight of the fact that the patient must come first.

Incidentally in reading of the successes and failures of Majocci, one sees surgery emerging from the dark ages and progressing to the present stage of effectiveness. By inference, at least, future advance is foreshadowed

The book is idealistic throughout, but it is a practical idealism which shows how dreams can be made to come true in spite of obstacles. It is such idealism that has resulted in the great advances that have been made. Without ideals there is no progress. The research worker in his laboratory may resent being called an idealist. Nevertheless he dreams of discovering some unknown germ and proceeds to work out his dream. The surgeon sees some weakness in his equipment or method of procedure and lets his imagination run wild with the result that another advance is made. Few people who knew Franklin Martin casually would call him a dreamer, yet he and his associates imagined the ideal hospital, organized the American College of Surgeons and proceeded to develop the hospital to its present stage of perfection. Before his death he saw a dream come true.

"Life and Death" is a book that should be read by every young physician and which would be of benefit also to those who have spent years in the practice of medicine. I strongly recommend it for the interns' library of the hospital.

Fee Splitting

During the past ten years a great deal of effort has been expended, chiefly at the initiative of the American College of Surgeons, in the attempt to combat exploitation of the patient by the division of fees. A district in Missouri conducted an educational campaign several years ago, frankly telling the people about fee splitting, an effort which was said to be successful.

Recently I have received a pamphlet from St. Joseph's Hospital, Milwaukee, in which the same idea is embodied. The pamphlet is given the patients and tells exactly how bills should be rendered, and what to expect from accounts which are improperly rendered.

If the patient receives a joint account, he is prompted to inquire as to the individual items. Surely there can be no more effective means of combating the division of fees.

Hospital lib

ning New Hospital Kitchens comprise but a few of the many subjects covered. Albert Pick Co., Inc.

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No. 441. **"Sanitation Products for the Hospital."** A complete catalogue of Surgical and Baby Soaps and their dispensers, Baby Oil, Disinfectants, Floor Finishes, Floor Waxes, Furniture Polish, and other Hospital and Institutional supplies. The Huntington Laboratories.

No. 440. **"Relating to the Selection, Arrangement and Installation of Sterilizers."** A twenty-four page booklet containing 38 drawings and plans of various types of sterilizer, urinal, autoclave, and condenser units, as well as floor plans of typical installations. American Sterilizer Company.

No. 436. An eight-page booklet describing and illustrating uses and installations of **Acousti-Celotex** in hospitals. The manner in which this material acts and methods of its installation are completely described. The Celotex Corporation.

No. 429. **"Vitamin C—Cevitamic Acid, Synthetic."** Nature, chemical characteristics, indications for administration, diagnosis of vitamin C deficiency, and the employment of the synthetic in a number of other conditions is discussed interestingly in this pamphlet. Hoffmann-La Roche, Inc.

No. 428. **"Vitamin C Titration** with Dichlor-phenolindophenol—A Method for the Diagnosis of Prescorbutic Conditions." Written in non-technical language, this pamphlet clearly explains the technique its title indicates. A bibliography of literature on this subject is also contained in the booklet. Hoffmann-La Roche, Inc.

No. 424. **"Why Matting?"** a four page folder issued by American Mat Corporation, describing the advantages of rubber matting for use in building lobbies.

No. 422. **"Program Sound Systems."** A descriptive, illustrated twelve-page booklet, explaining the application of the Western Electric Company's sound distribution system.

No. 413. **"Standardized Hospital Record Forms."** Approved forms for professional service, administrative, accounting and all other departments. Physicians' Record Co.

No. 412. **"Alphabetical Indexing,"** describing the alphabetical disease and operation indexes; also other essential indexes as statistics cards, patients', physicians', X-ray and laboratory. Physicians' Record Co.

No. 407. A series of brochures describing the following **Curity products:** Sterilization and bacteriological control, plain and chromic catgut, the advance in absorption control, gastro-intestinal sutures, dermal and tension sutures. Published by the Lewis Manufacturing Co.

No. 404. **"Modern Surgical Illumination."** A new pamphlet describing recent and important developments in surgical illumination, prepared by the Wilmot Castle Company.

No. 392. **"Maintenance Cleaning Illustrated."** This booklet covers the entire field of maintenance cleaning. J. B. Ford Co.

No. 376. **"Wyandotte Products for Hospitals** and Institutions" explains how all cleaning in the hospital and institution can be done, and how every rule of thorough, safe and economical cleaning can be easily followed. The J. B. Ford Co., Wyandotte, Mich.

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T. R. PONTON, B.A., M.D., Editor

As The

THE INDIGENT IN THE VOLUNTARY HOSPITAL

» » As information and experience accumulate, we are becoming increasingly convinced of the necessity for state support of the indigent sick. Our opinion has received additional confirmation by an editorial in, "The Hospital," the official publication of the British Hospital Association.

We often find that in Great Britain, the older of the English speaking countries, events mature earlier than in the younger countries. This is illustrated in the editorial mentioned, which states, "The days of almost complete dependence on the well-to-do are over." The situation in England is being met by increased collections from the patients themselves and by the contributary schemes allied to our group hospitalization.

In this country the question of support of the voluntary hospital is becoming increasingly difficult of solution. Those who are in a position to speak with authority state that gifts and contributions to charity are not increasing, as it was hoped they would after the great depression. Some with whom we have talked took a very pessimistic attitude and could see nothing but the end of the voluntary hospital. Others were more optimistic, but had nothing to support their optimism except religious faith. So far, no solution of the problem has been offered.

Why should we not be businesslike in our charity? To do this it is not necessary to sacrifice our Christianity nor is it advisable to discourage charity. The care of the indigent when he is well has been accepted as a governmental responsibility; why not when he is sick?

New York has recognized the responsibility in principle but has not yet fully lived up to it in practice. Other states have also recognized their responsibility. To get all governmental bodies to provide adequately for their indigent sick will take years of effort and the movement, which has already started, should be vigorously pushed if the voluntary hospitals are to avoid being placed in an increasingly embarrassing financial position.

EFFECTIVE PUBLICITY

» » We are constantly deploring the fact that hospital publicity is not as effective as it should be. Proper publicity is as necessary to the hospital as is food to the individual but, in order to get to the listener or reader, it must convey facts in such a manner that they will be listened to or read. At the same time the code of ethics must be observed.

We have always contended that such publicity was both possible and desirable and some recent material released by the Hospital Association of Pennsylvania confirms our opinion. The association, through its president, is officially releasing a systematized series of articles to the press. These are brief and to the point. They contain definite statements which are informative and of value. One, which we have before us, contains such statements as the following:

" 'Hospitals', says Ralph de Palma, noted auto race driver, veteran of six major crack-ups, 'are the best form of insurance a motorist can have. That's why I think that the people should support the voluntary hospitals of their city'."

This is a direct appeal such as the public have come to expect in advertising. Other releases contain statements of fact about some specific department or activity. None is of the hazy, indefinite type. All are sales talk which we have to learn to put over.

OCCUPATIONAL THERAPY IN THE ACTIVE HOSPITAL

» » Occupational therapy has, for a considerable time, been recognized as a valuable adjuvant to treatment in the chronic and the psychiatric hospital. The patient with an acute illness enters strange surroundings with a feeling of dread, the degree depending on his familiarity with the hospital and his confidence in it and his medical advisor. To keep his mind occupied is not only common

Editors See It

humanity, but it also has a definite therapeutic value. No person today questions the influence of the contented mind over the disturbed body.

In the December issue of "The Canadian Nurse" is an article showing the value of this form of therapy in a children's hospital, and how it can be carried out. To quote from the article in question:

"The human organism has a way of responding to the familiar in a given situation and we have found that play, because it is a normal part of every child's daily life and is therefore familiar, tends to release visceral tensions set up by fear and nostalgia and serves to orient the newly-admitted child to his strange smelling and foreboding environment, the hospital."

HOSPITAL MANAGEMENT is fortunate in being able to present in this issue, an article by the occupational therapist in charge of the department in a large, active hospital. In conversation with the administrator about a year ago, we asked him if the department paid. He stated very definitely that financially it could be nothing but a liability, but that from a humanitarian point of view and in favoring recovery, it was such an asset that it amply justified the financial deficit.

LEADERSHIP

» » We were very much impressed with a remark made by Dr. Clarence C. Little, managing director of the American Society for the Control of Cancer, in his address at the annual banquet of the American College of Hospital Administrators, in which he advocated that we in the hospital "break loose from the fear of other organizations and look at our problems independently"; that "we strengthen ourselves and forget our fear of others." The central thought appeared to be that hospitals and hospital organizations have shown almost an inferiority complex in their hesitation to express themselves; that they have often waited too long before taking independent action.

We do not think that Dr. Little meant that the hospital should act contrary to the best interests of, or in opposition to, those other organizations with whom they must be associated in the care of the sick. If we thought this, we would disagree with him.

The hospitals of the United States now constitute one of the major activities of the nation, both financially and from the point of view of general well being. and should exert the influence due to and to be expected from an enterprise of such magnitude. More often should they assume leadership in both national and local problems which are primarily their concern.

Within the past few years there has been evidence of this leadership in the joint committee which has so ably watched Federal legislation and in the organization and development of plans designed to help the moderate wage earner in his time of illness. Apparently another serious question now confronts the hospitals of the country as a whole—a shortage of nurses.

From various sources come conflicting reports. Some of these state that insofar as the hospital is concerned there is an acute shortage of nurses; others claim that the supply is available to meet the demand. In the meantime we note with some misgiving that in several centers practical nurses are being trained.

The question is of vital importance to both the hospital field and the nursing profession. The hospital needs facts, not opinions of any individual or small group of individuals. Three questions require an authoritative answer at once, not one or two or more years from now!

1. Is there a shortage of nurses insofar as hospital service is concerned?
2. If there are not sufficient nurses available to meet the requirements of hospitals, what is the reason?
3. If there is not a sufficient supply of nurses to meet the hospital demand, what is the remedy, (a) immediate, (b) as a long term policy?

The two bodies on whom the responsibility for solving this problem appears to rest are the American Hospital Association and the American Nurses' Association. Neither can work out a solution alone.

More on this subject in a future issue!

Mutual Responsibility

FOR THE MEDICAL RECORD

The medical record is the document on which is based all accurate knowledge of the quality of the work done in the hospital. In the present article, Doctor Ponton plainly sets forth the mutual responsibility for securing this record.

By THOMAS R. PONTON, M. D.
Editor, HOSPITAL MANAGEMENT

» » » MUCH HAS BEEN WRITTEN and said regarding the necessity for and uses of medical records in the hospital; so much that these points need no further discussion. It is universally admitted that the practice of medicine as it has evolved in the modern hospital is a necessity, that the patient placed under the care of the modern physician in the hospital of today cannot be properly treated unless the physician keeps, or has kept for him, an accurate and complete statement of all influences that may have a bearing on the successful combating of the disease or disability and that all treatment and the resulting development of symptoms be accurately stated in writing.

Nor is the usefulness of such a medical record a subject for disagreement. No hospital or physician denies that the written statement of all points having a bearing on the illness or disability serves the essentially useful purpose of aiding the busy physician in the care of his patient; and the busier the physician the more necessary and useful does he find the systematized statement of facts and events. It is not necessary to discuss the uses of the medical record apart from those which directly concern the patient. They are acknowledged and are natural sequences of the necessity for and usefulness of the documents required for and used in the care of the patient.

In spite of the fact that there are few or none in the hospital, including the most careless, who do not acknowledge these facts, yet the medical record is not as complete a document as it should be. In many cases it is merely a form, statements being entered only to fill a prescribed space without real consideration of their bearing on the patient in his present illness or disability. In other cases, facts and findings of importance are carefully written, but this is done without system, no attempt being made at correlation and building up a well-rounded picture. Such records contain valuable data but it is so difficult to find what is wanted or to secure a bird's eye view of the case that they lose a great percentage of their value.

Medical records are gradually improving and in some instances are valuable documents from all points of view, but they have not attained anything near the degree of perfection that should have been reached when one considers the concerted effort that has been put forth during the past twenty years. The chief reason for this appears to be a lack of that type of realization of responsibility which will result in the necessary effort.

The medical record is automatically divided into the nursing section and the medical section, different groups in the hospital being distinctly responsible for the securing of each, and the administrator being required by the governing body to see that each group adequately fulfills its responsibility.

Nursing Section of the Patient's Record

The nursing section of the patient's record is essentially a statement of facts, it being generally conceded that the nurse should not state conclusions and deductions but should leave this function to the physician. These facts consist of treatment ordered and carried out and the symptoms she observes as a result of or in spite of the treatment administered. These are usually recorded on standard forms: the Graphic Chart, the Nurses' Record of Treatment and Symptoms and the Physicians' Orders.

Since the nurse, whether graduate or undergraduate, is under definite disciplinary control, the completeness and accuracy of her records will depend entirely on the standards demanded by the hospital.

Responsibility of Floor Nurses

The responsibility for keeping proper nurses' records rests, first of all, with the floor nurse, whether she be a graduate or an undergraduate. It is she who carries out treatment and observes symptoms, and, therefore, she is the only person who is competent to record what has been done and observed. This statement implies a great deal more than appears on the surface.

First, it implies that the nurse carries out the treatment and is an observer of symptoms. Cultivation of the power of observation is an important part of a nurse's training, for if she cannot observe, she cannot transmit to the physician symptoms which may be of importance.

Second, she must learn to discriminate. In some cases an apparently trivial event may have a vital significance and the nurse must have sufficient knowledge to be aware of this fact. The development of this power to select is one of the important justifications for the advanced education of nurses.

Third, she must acquire a facility to record. The nurse's notes must be concise statements recorded in

an orderly manner in order that the trends shown may be easily followed.

Responsibility of Those Superior to Floor Nurses

The supervisor is responsible for everything that occurs on her floor and this must be interpreted to include the nurses' records. With the undergraduate, this may include conference with the nurse to assist in selection, but at least the supervisor must be held responsible for overseeing that which is written. With graduate nurses, the conference which is a part of teaching should not be necessary, but supervision is equally essential if the nurses' records are to be of value and conform to the standards of the particular hospital.

The instructor,when there is a school of nursing, must teach the undergraduate nurse all that has been discussed regarding the nurses' section of the record. This is done in classroom, but instruction in theory is largely lost unless there is systematized application to practice. In order that this may be accomplished, the instructor must study the records as written and discuss them with the nurses. Whether this is done on the floors or by discussion of actual records in the office or class room depends entirely on the preference of the instructor, provided this preference is based on results secured and not on the convenience of the instructor.

Finally, the superintendent of nurses is responsible for everything that concerns the department of nursing. In any but the smallest hospital she must of necessity delegate the greater part of the supervision of nurses' records to her subordinates. but as a minimum she must assure herself that they conform to accepted standards and she can do this only by periodically reading records selected at random either on the floors or in the files.

Medical Section of the Patient's Record

It is not within the scope of the present article to discuss the contents and form of the patient's record. The outline of contents has been for years established by the American College of Surgeons and this has been generally accepted as the approved standard. In view of the errors of omission it may be of advantage to attempt to fix responsibility for the dificiencies which are so well recognized.

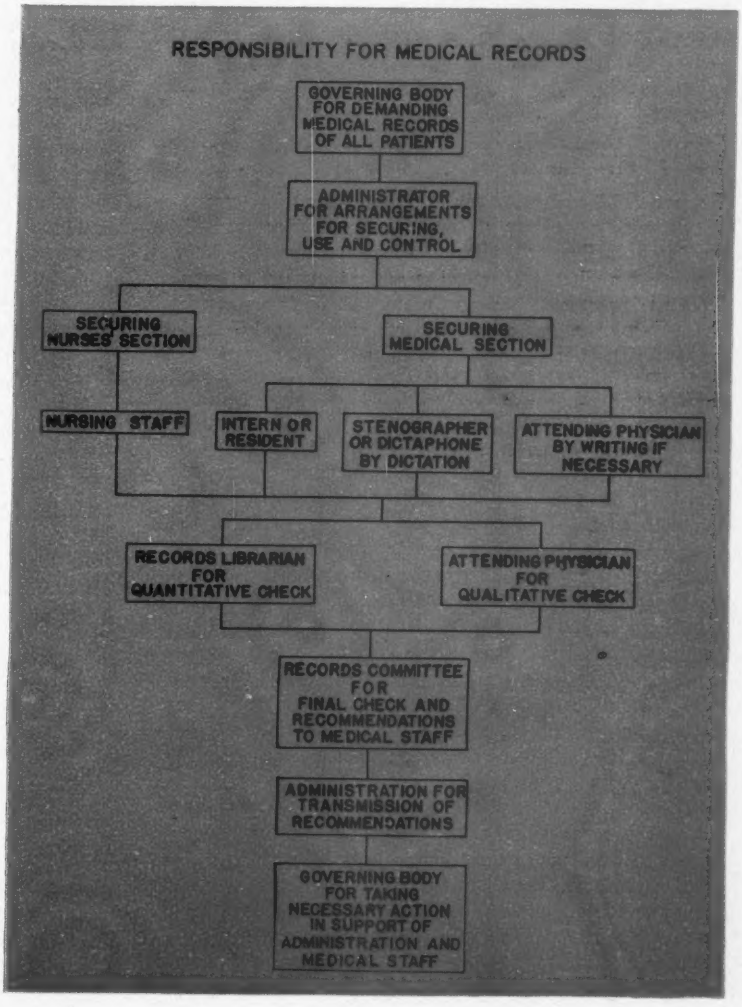
Responsibility of the Hospital

The medical section of the patient's record can never be regarded as a responsibility of any person or persons except the medical staff and its individual members, but the hospital must accept responsibility for rendering every possible assistance. Provision of forms and a suitable place in which the work may be done is a responsibility that is generally accepted, but there are others which are of equal or greater importance. If it is at all possible, it is very desirable that the physician be given assistance to relieve him of much of the mechanical work of writing. This may be provided by means of a dictaphone or a stenographer.

The dictaphone is very satisfactory if it is properly used. It saves the time of the stenographer, avoiding the necessity for her to wait around for the convenience of the physician and it allows the physician to dictate at his convenience and without interruption. It has, however, one very grave defect. It does not provide any means of reminding the physician to dictate.

A good stenographer, trained in taking medical dictation, can be of enormous value if properly used. She can find out what records are incomplete and remind the delinquent staff member. When he has dictated his report, her typed transcript is neat, legible and orderly; therefore, it retains all the value put into it by the physician.

Some hospitals go too far in providing help to the physicians in that they allow a record librarian, a nurse or some other trained person to secure a part of the record. This is a very dangerous system which should never be sanctioned. The part of the record taken by this person who has not had medical training may be very voluminous but it is not a study of the individual patient and his disease. It is a routine formal record and will probably develop into the worst form of camouflage.


RESPONSIBILITY FOR MEDICAL RECORDS
GOVERNING BODY FOR DEMANDING MEDICAL RECORDS OF ALL PATIENTS
ADMINISTRATOR FOR ARRANGEMENTS FOR SECURING, USE AND CONTROL
SECURING NURSES' SECTION
SECURING MEDICAL SECTION
NURSING STAFF
INTERN OR RESIDENT
STENOGRAPHER OR DICTAPHONE BY DICTATION
ATTENDING PHYSICIAN BY WRITING IF NECESSARY
RECORDS LIBRARIAN FOR QUANTITATIVE CHECK
ATTENDING PHYSICIAN FOR QUALITATIVE CHECK
RECORDS COMMITTEE FOR FINAL CHECK AND RECOMMENDATIONS TO MEDICAL STAFF
ADMINISTRATION FOR TRANSMISSION OF RECOMMENDATIONS
GOVERNING BODY FOR TAKING NECESSARY ACTION IN SUPPORT OF ADMINISTRATION AND MEDICAL STAFF

Responsibility of the Intern

For the purposes of the present discussion, the word "intern" is used to include not only the intern in the ordinary sense, but also those graduate physicians who are so frequently employed in the smaller hospitals which feel the need for having a physician constantly in the institution but cannot qualify for internship.

These men spend their time in the hospital primarily as a step in their education and if the members of the attending staff pay sufficient attention to them, criticizing their case studies and instructing them in other ways, they will give valuable service, not only in securing medical records, but also in relieving the physician of many of his duties in caring for his patients. They are human, however, and if left to themselves will naturally devote practically all their time to cases which interest them, doing for others only that which they are obliged to do.

Responsibility of the Resident Physician

In the larger hospitals having a number of interns it is usual to find senior men who have served internships, but are continuing their studies, perhaps in some specialty. These residents are placed in immediate control of groups of interns who will write most of the records, but they themselves should always continue to write some records in order not to get out of the habit. Their chief duty and responsibility, insofar as the patients' records are concerned, is, however, to supervise the work of the interns. They should be responsible for studying all records written by the interns in their service, seeing that they are complete and correcting any inaccuracies before the record is presented to the attending physician for his final approval.

Responsibility of the Adjunct Department

Of the responsibility of the adjunct departments little need be said. They are all in a consulting capacity. They are asked to make specified examinations or to carry on a predetermined line of treatment. Their reports of these examinations or treatments are usually made promptly and become a part of the patient's record.

Responsibility of the Attending Physician

In the last analysis, the attending physician is responsible for the care of the patient and for the record of all phases of that care. No matter how anxious the hospital and those associated with it may be to lighten his work, he must assure himself that the medical section of the record is a true and complete story of the patient in his illness. If he dictates he must read that which is transcribed to see that his statements, as transcribed, are accurate and complete. If an intern writes the record the attending physician must make certain that he agrees with all the findings and the deductions that have been recorded. In case of a difference of opinion from that recorded by the intern, he must first make certain whether he or the intern is correct and, if the intern is wrong, see that the record is corrected.

Physicians, almost without exception, have acknowledged this responsibility, but many, for various reasons, have not lived up to their verbal acknowledgment. One of these reasons, the correction of which lies within the power of the hospital, is that those in the hospital have been guilty of "nagging" about small matters. The most notable example is in the matter of signature. Of course the physician should sign the record as signifying his approval of the contents, but why should he sign it in a dozen or more places? Let there be one place in which he states over his signature that he agrees with the statements contained. Another noteworthy example is in the matter of diagnosis. When the physician arranges for admission of the patient he states his working diagnosis to the admitting officer. That statement should be recorded and stand as the admitting diagnosis instead of pestering the physician to write it himself. Again with the final diagnosis, perhaps the physician chooses to record it after he has completed his examination or at the end of the record. If, for ease of reference, it is desired to have it elsewhere, let the librarian transcribe it instead of bothering the physician. "Nagging" about unimportant detail and formality has done much to make a large number of physicians feel that the hospital is asking too much of them and has given others an excuse for neglecting the records of their patients or making them merely a matter of form.

Responsibility of the Medical Records Committee

The medical records committee is appointed by and represents the medical staff in its appraisal of the patients' records. If case action of any kind becomes necessary to enforcement of requirements, the committee may work directly with the administrator, but it is usual for it to take the more roundabout route and report to the medical staff, which then acts with the administrator.

While the medical records committee may have such functions as to give advice in selection of forms and systems, its chief responsibility is to review the records of patients. It is quite manifest that this committee cannot review the record as a personal document, that is, as a study of the patient as affected by the disease or disability. It cannot know the patient so must view the record as the story of a disease. The points to be considered would therefore be:

1. Is the resistance or the lack of resistance and disease tendencies clearly shown?
2. Is the diagnosis clearly established by adequate history and examination?
3. Is the treatment fully described?
4. If an operative case, is the preoperative diagnosis confirmed by the pathology found?
5. Is the progress (and post-operative care) fully described?
6. Is the final result shown in sufficient detail?

If this committee is to fulfil its responsibility, it cannot be perfunctory in its activity. It must remember that it has no personal relationship with the individual physician but that it represents the medical staff as a whole and is directly or indirectly advisory to the administration. It should therefore meet at frequent intervals, review the records conscientiously, follow up those that are incomplete by second and even third reviews and report conditions together with recommendations to the staff as a whole. These recommendations may even go to the extent of recommending suspension of a delinquent staff member.

Responsibility of the Administration

The governing body, as the final authority in the hospital, is responsible for having on file a complete and accurate record of every patient treated, a responsibility

(Continued on page 28)

Figure 1 (right). Oxygen regular with calibrated gauge registering flow in litres per minute.

Use of Oxygen Therapy

By MORRIS ECKMAN, B. S.
New York, N. Y.

» » » THE PURPOSE of this article is to describe some of the simple types of equipment for administration of oxygen. It is unfortunate that in many institutions old, out-dated equipment, which does not meet the two primary standards for gas administration, is still in use. Any method which does not economically provide adequate oxygen or assure the comfort of the patient should not be used.

Many hospitals still use so-called medical oxygen in low pressure cylinders. This oxygen is much more expensive and inconvenient to handle than commercial oxygen. The latter is compressed in high pressure cylinders which contain 220 cu. ft. or approximately 6000 liters. There is no difference in the purity of the gases, the commercial oxygen meeting U.S.P. standards. The low pressure medical oxygen cylinder contains about one twentieth the quantity of gas as the high pressure commercial tanks and thus requires 20 times the handling of cylinders and changing of gauges.

The 220 cu. ft. cylinder should be fitted with a two stage reducing valve (Figure No. 1) whose flow is calibrated in liters per minute. An ordinary needle valve is absolutely unsuited for therapeutic use in the simpler apparatus because of the lack of control of accurate flow and because of the dangers inherent in its construction. With the two stage regulator any flow may be set and the valve will continue delivering that quantity of gas until the tank is empty. With the needle valve the flow per minute will fall as the cylinder empties unless frequent adjustment of the valve is made. The gas leaves the two stage regulator at a low pressure while with the needle valve the pressure of the gas leaving the valve equals the pressure in the cylinder. Should a needle valve be used with a nasal catheter the high pressure of the tank may be transmitted to the nasopharynx of the patient with consequent injury.

The simplest efficient type oxygen therapy apparatus

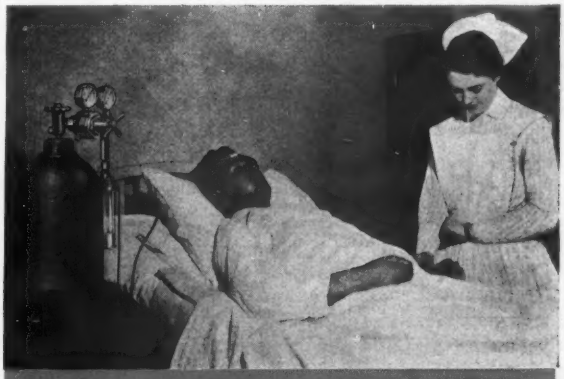


Figure 2. Administration of oxygen with single nasal catheter.

Figure 3. Administration of oxygen by use of the face mask.

is the nasal catheter (Figure No. 2). It consists of a calibrated reducing valve, water bottle or humidifier, rubber tubing, a metal connecting tube and a catheter. The catheter, No. 10 or No. 12 French, is perforated within its terminal one inch with six or eight small holes so that a single stream of oxygen does not impinge on the mucous membrane. According to the technique of Barach,[1] the catheter is inserted into the nasopharynx to within one quarter of an inch of the posterior pharyngeal wall and is then taped across the bridge of the nose and forehead. A flow of four liters per minute will result in an oxygen concentration in the inspired air of 35 to 38 per cent. If higher concentrations are desired a double catheter should be used. With the double catheter, flows of eight liters per minute will yield 42 to 44 per cent in the inspired air. It is very important to saturate the oxygen with water so that drying of the mucous membrane does not take place.

Waters and Wineland[2] have reported still higher concentrations of oxygen in the inspired air when the catheter is placed in the oral pharynx opposite the uvula. It is the experience of some that patients do not tolerate this method as well as the nasopharyngeal method described above.* Marriot and Robson[3] have described a metal catheter which consists of a forked metal canula, held in place over the nose by an adaptation of a laryngologist's head mirror strap. To the two ends of the canula are attached soft rubber catheters which are inserted in the nose. Bullowa[4] prefers the metal nasal inhaler which is similar to Marriot and Robson's metal catheter: the tips fit just inside the nostrils. It is Barach's[5] experience that this method does not yield higher concentrations than the inexpensive nasal catheter described above.

In every one of the above methods of administration care must be taken to obtain efficient humidification of the oxygen entering the nose. One way to judge the relative merits of the many types of humidifiers sold for catheter work is to run a fixed quantity of oxygen from a tank through the humidifier. By weighing the humidifier before and after, the quantity of moisture taken up by the gas can readily be determined.

A more elaborate method for administering oxygen is the face mask. Most masks are unsuited for long continuous administration because of the discomfort to the patient. In most cases the mask is not ventilated and as a result is found to be hot and humid. Campbell originated a face mask[6] which has been modified by Barach[7], The mask (Figure No. 3) is fastened across the bridge of the nose and molded to conform to the patient's face. Two metal ear loops, or two strings tied behind the head serve to hold the mask in position. Unmoistened oxygen is fed into the mask at a rate of from 6 to 10 liters per minute. An air injector attached to the gauge increases the flow of gases into the mask and thus facilitates the removal of hot, moist and CO_2 laden expired air. The concentrations of oxygen in the inspired air at various flows are shown in Figure No. 4. They compare favorably with the oxygen tent.

There are two different types of oxygen tents, the motor driven circulation type and the thermal circulation type.

*Other authorities do not find that there is any complaint from the patient provided the oxygen is properly humidified and is delivered through a catheter having a sufficient number of holes near the tip.—Editor.

LITER FLOW PER MINUTE	% OXYGEN IN INSPIRED AIR
6	44
8	48
10	52
12	55

Figure 4

The latter have their limitations since humidity and temperature control are not so easily obtained.

The motor driven tent (Figure No. 5) consists of a canopy and air conditioner. A motor blower circulates the oxygen enriched atmosphere from the canopy through the air conditioner, where the gases are cooled and dehumidified by direct passage over ice and then returned to the canopy. Oxygen may be added at a rate of from 8 to 10 liters per minute after the initial purging, but some therapists consider this rate to be unusually high. No soda lime is found necessary when using these flows since this quantity of oxygen is found to wash out the CO_2 eliminated by the patient. The use of soda lime rather than higher flows of oxygen to eliminate the CO_2 is fallacious since in the normal use of a tent small flows of oxygen will be found inadequate to maintain the necessary concentrations of oxygen in the tent.

Humidities of between 40 to 60 per cent are easily maintained. The temperature is controlled by a rheostat attached to the motor blower or by a by-pass so that ranges of from 5 to 30 degrees below room temperature can readily be obtained. During a recent heat spell in New York with the temperature at 95 degrees, motor-driven tents were being run between 60 and 70 degrees.

This wide temperature range is especially valuable in the treatment of post-operative thyroidectomy cases where cold dry atmospheres are found to be invaluable.

The thermal circulation type tents consist of an ice cabinet and canopy. The warm gases of the canopy rise and enter the ice compartment at the top where they are cooled. The cooled gas falls and re-enters the canopy at the bottom. Control of cooling is achieved by dampers attached to the ice cabinet which admit varying quantities of warm gas from the canopy.

Burgess[8] has developed an open top thermal circulation tent (Figure No. 6) which is suitable for use especially with infants and children. An effective oxygen concentration is easily maintained provided the apparatus is used in a room free from drafts. This apparatus has the advantage of simplicity and inexpensiveness although the control of temperature and humidity is not as effective as in a motor driven tent.

Too much stress cannot be laid on the importance of the question of dosage of oxygen in oxygen tents. In a recent

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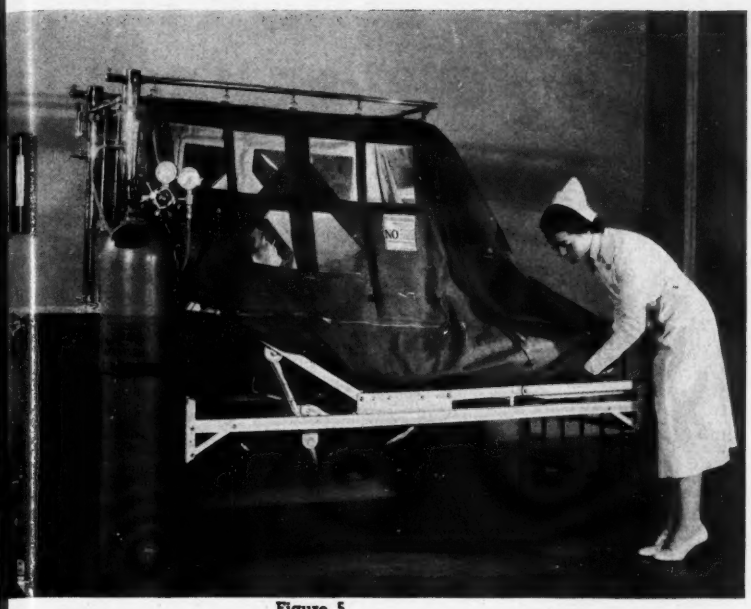


Figure 5

Figure 8

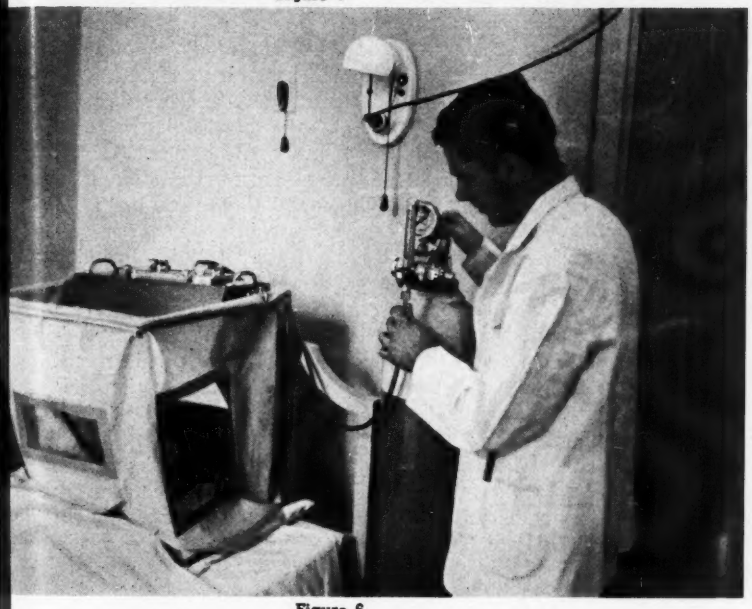


Figure 6

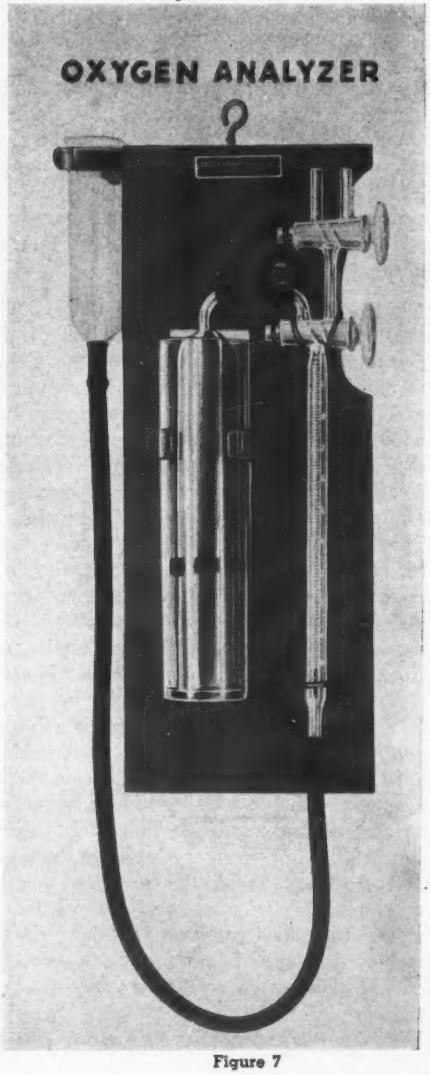


Figure 7

Figure 4 (on the opposite page). Concentration of oxygen in the inspired air when using the face mask.

Figure 5. A motor-driven oxygen tent.

Figure 6. An open top thermal circulation oxygen tent.

Figure 7. The Binger type testboard for oxygen concentration.

Figure 8. The Riseman type testboard for oxygen concentration.

Selection of Personnel

By E. MURIEL ANSCOMBE, F.A.C.H.A.
Administrator, The Jewish Hospital, St. Louis, Mo.

» » » The SELECTION OF PERSONNEL is a subject of practically universal interest. It concerns the general public because proper selection, more than any other factor, determines the type of service which the hospital renders to patients. It is of great interest to the hospital personnel, because each employee must be in a position which utilizes his capacities properly and must also be associated with capable and conscientious fellow-workers, if his work is to be done in a way satisfactory to himself as well as to the institution for which he is working.

The responsibility for selection belongs primarily to the Board of Directors or Trustees of the hospital, because it rests with them to choose the head of the organization. The superintendent or administrator whom they select will be responsible directly to the board for the choice of all other members of the personnel, as well as for carrying out hospital policy and performance of the procedures which are delegated to them. The duties of the administrator include not only the selection, but also direction, supervision, maintenance of the morale, and development of the ability and skill of workers. Under his direction are employees who directly render health care, who maintain the hospital building and facilities, render community health service through the clinic and social service bureau, teach the student nurses, and carry on the many other activities which are a part of the program of the modern hospital.

Choice of the Head

Obviously, the proper functioning of the institution depends primarily upon choosing the right head. The administrator must, first of all, have business knowledge and integrity, in fact all of the necessary qualifications of a good business manager, because conducting a large, modern hospital is comparable, when considered strictly from a business point of view, to conducting a large, modern commercial institution. It is most important that he know how to use hospital funds properly so that the greatest possible returns in rendering needed health care are realized. A knowledge of the problems, viewpoint, policies, and ethics of the medical and nursing professions is also needed by the administrator, so that he may work with them properly and understandingly. He is dealing with the most precious commodity, human life, and needs a background of information regarding the work of all of the health professions, in order to be able to cooperate with them to prevent disease and promote health. Besides, his institution is a member of a group of health agencies serving the community, and he must, therefore, have a live interest in community health problems and activities.

To be able to obtain the services of superior individuals as employees, if for no other reason, the superintendent should have good contacts throughout the country. The most desirable candidates for any worth while position are sought when normal conditions prevail and leaders in each field are informed of contemplated changes in personnel. They know what individuals are doing or are capable of doing a good piece of work, and are willing to help place able persons in positions in which they can develop and utilize their latent possibilities. The administrator should also know which educational institutions are giving adequate or superior training and what reliance can be placed upon recommendations. He must know how to use the services of employment bureaus intelligently and which bureaus study the background of applicants and make an intelligent selection of the ones whom they refer.

Selection of Department Heads

Because the selection of department heads devolves upon the administrator, he must, first of all, be a good judge of character, not superficially or abstractly, but from a practical and objective point of view. He must not only be a leader himself, but he should be able to choose leaders. A leader himself, he should possess the qualities which he desires in his subordinates and they must be a reflection of his personality because he must entrust to them the carrying out of his policies. This does not mean that he should choose what are popularly called "rubber stamps" or "yes men" as department heads. Rather this is something against which he must guard very carefully. What is needed in key positions, in fact in all positions involving responsibility, is the intelligent thinker who can independently determine the proper course of action and proceed intelligently in new as well as in familiar situations. It is not enough that employees in key positions be trained thinkers; they must be trained doers.

It is necessary that the administrator have a knowledge of the various professional groups and good contacts with them to know what they require of their members in the way of qualifications. Only with this knowledge can he judge the qualifications of department heads properly. For example, he should know the necessary qualifications of residents, interns, head nurses, pathologists, auditors, pharmacists, engineers, laundry heads, and many other workers. What do their professions demand of these people, for them to be considered qualified to hold their positions? What schools give first-class instruction or training in their specialists? Are the institutions or organizations with which they have been associated of a high type which have improved their skill, developed their capacities, and given them a broad outlook so that they seek to render the best possible service and advance? Have they worked under a head who has developed their capacities? Did they leave because of being capable of more than was asked of them in the position which they held, or because of not being able to meet the requirements?

A personal interview is important, because the person with a fine background of education and experience obtained under the best auspices may have personality

difficulties which will handicap him in a responsible position to such an extent as to nullify his ability to do a good piece of work. It must not be overlooked, of course, that there may be positions for which the candidate with personality difficulties would be handicapped but that he may be well fitted for others, or that he may be assisted to overcome or offset these difficulties. Because the persons in key positions must be able to solve personality problems which arise in their own departments, the ability to solve such problems in their own lives, as shown by good personal social adjustment, is of the utmost importance.

Criteria for Selection of Personnel

A certain amount of progress is being made in testing people to determine their fitness to hold positions. Psychologists make certain claims in respect to having determined the grade of intelligence needed for various kinds of positions. The fact that they measure intelligence in terms of years of mental age to present their findings, stating that a mental age of 18.5 years or over is required for a business executive, 16 to 18.4 years for a physician, and 13.6 to 15 years for a sales clerk, for example, is rather confusing, is likely to create skepticism about the validity of their findings, and may handicap the use of the tests. Psychologists themselves agree that the measurement of abstract intelligence is still in its rudimentary stages, and they have scarcely started to measure social intelligence. It is appreciated that many important factors are involved in the individual's ability to adapt himself to his environment and that this ability cannot be measured in a way that is generally acceptable by any methods so far devised.

It is generally admitted that the type of intelligence manifested in adjustment to the environment in a way to achieve the position of capable leadership is the highest. If psychological measurement had progressed to the point where it could measure objectively the qualities which make for ability in leadership and the other social abilities, the task of personnel selection would be much simpler than at present. Now, the administrator must depend largely upon his own judgment in making the selection of persons for key positions, and realizes that his judgment is necessarily fallible. In making these selections, he must judge the past record of the applicant, evaluating references and the opinion of his qualifications and work as expressed by others. A personal interview is important, as has already been mentioned. It is admitted, however, that even the person who is recognized as a keen judge of character may err in passing opinion upon an applicant in a single interview. There are many fundamental merits or defects of character that may become manifest only after considerable experience with the individual.

The administrator is looking for such qualities as loyalty, ability to adjust to new situations, take problems, understand and solve them, and willingness to do even more than should ordinarily be expected of the employee when an emergency arises. Ability to work with others without friction is also needed. The facts about the candidate's capabilities in these respects may be difficult to ascertain. The persons consulted as references may lack candor or be unable to judge qualifications for the position for which the candidate is being considered in an intelligent manner. The candidate's previous employment may not have given him an opportunity to show what he can do in respect to factors which are important in connection with the position, or he may have left his previous position because he was put in a situation which was unfair to him and the circumstances are difficult to explain in an acceptable manner. The applicant with a personality defect may be able to conceal it during an interview, but, once secure in the position, may allow it to become evident.

To find the right person for any position is obviously a matter which must be considered from two points of view, that of the candidate and that of the organization of which he is to become a part. Any applicant deserves having the facts about the position, for which he is applying presented to him in a fair and candid manner, just as he is expected to present his own qualifications to fill it. To be able to do this, the administrator needs, first of all, to know the facts about the position, the importance of which has already been considered from another point of view, that of being able to judge the applicant's qualifications for the job. Any person hiring an employee should be able not only to do this, but to assist the prospective applicant to determine his own fitness for the job and judge whether he can fill it in such a way as to enjoy his work and obtain there the personal satisfaction gained from a job well done.

Courtesy to Applicants

The courtesies due to applicants for positions must not be overlooked. Arrangements should be made so that candidates are not kept waiting indefinitely for an appointment. If personal shortcomings which are judged to unfit the candidate for the position or which might handicap him in holding it are brought to the applicant's attention, it should be in the spirit of helpfulness, and done kindly and constructively, if at all. A lack of consideration in this respect may be the result of mere thoughtlessness, but can possibly spoil a life. An ability to understand the other person's point of view is especially important in employer-employee relations.

In most hospitals, probably in all of the larger ones, the responsibility of filling positions subordinate to the key positions rests with the key employees, so ability in personnel selection and direction is an important factor to take into consideration in choosing department heads. In order to be able to entrust them to employ subordinates, it will be necessary for the administrator to make sure that they understand the principles and both know and adhere to his policies. A certain amount of supervision will probably be necessary, more so in some cases than others, because the best candidate for the position of head of the school of nursing, laboratory, diet kitchen, or laundry, for example, may have difficulty in choosing capable assistants. A person of strong personality may by preference, though possibly unconsciously, choose assistants who are weak in the qualities of leadership and initiative. A person with an unduly optimistic view of human nature or who is very kindly may attempt to conduct his department with assistants who are incompetent or either unable or unwilling to work properly under direction or with associates. The administrator must take this into account and while entrusting the selection of subordinates to the department heads, continue to advise them and give assistance as needed.

The whole organization must realize that the right person must be found for every job, which means the person who is completely qualified for the specific work which he is to do. Any position for which a superior individual is

(Continued on page 41)

OCCUPATIONAL THERAPY IN THE GENERAL HOSPITAL

By WINIFRED BRAINERD
Director, Occupational Therapy Department, Presbyterian Hospital, Chicago, Ill.

» » » THE PRESBYTERIAN HOSPITAL of the City of Chicago was started in 1883, and is therefore 54 years old. It is a teaching hospital affiliated with Rush Medical College of the University of Chicago, and it has its own school of nursing education. Its occupational therapy department has been in continuous operation for the past twenty years, even through a depression which curtailed occupational therapy in many hospitals. There can be only one reason for this longevity: it must meet the exacting test of all things that endure in this world of competition, and it must pay. There is more than one method of paying; dollars and cents may be a tangible evidence of service rendered, but there are situations in which intangibles prove themselves good business investments. The tangible evidence of the value of occupational therapy in mental and tuberculous hospitals has been proved beyond the shadow of a doubt, and if the evidence of its value in general hospitals were equally manifest, undoubtedly more general hospitals would provide this therapeutic adjunct to the care of their patients.

The capacity of Presbyterian Hospital is 400 beds. The average stay of the patient population is 9.6 days. The occupational therapy department treats an average of fifty patients a week the year 'round. Of these fifty patients, possibly three will be long time cases. A study was made of the patients referred to the occupational therapy department last February, for a period of one month only. There are five medical services and five surgical services on the staff of the hospital and it was found that each service was represented by one or more patients and that twenty-three individual doctors were represented. A committee of the staff sent a questionnaire to each staff member represented by one or more of the fifty patients. The purpose of the questionnaire was to determine what measure of support and approval the department was receiving from the physicians. The chairman of the committee said that if one-third of the questionnaires were returned he would be satisfied. Over one-half of the 73 sent out were returned and in every case except one where a mistake was made in sending the questionnaire, the doctor had referred the patient, and the service rendered by the occupational therapy department had been satisfactory. Such a response on the part of the staff is an indication that occupational therapy has a place in a general hospital.

Long time cases and chronics of various types present a special problem in any institution not specifically organized for their peculiar needs. Physically, the problem may fit into the general scheme of things, but mentally, unless a patient has resources within himself for study or reading or has an absorbing hobby to divert his attention from his immediate difficulties, the picture presented may be a sorry one. Fear, worry and discouragement may so hinder a patient's progress that mind as well as body may challenge the skill of the physician. Most general hospitals have classical long time cases and I shall relate briefly the story of such a case at Presbyterian Hospital.

The patient was a young man, 20 years old. He came from a neighboring state, from a town whose total population numbered sixty. He completed the sixth grade in school and then went to work. He was strong and husky and he got a job as "hind end man" on a river boat on the Mississippi river. He was industrious and thrifty and he saved enough money to buy a Ford truck and start a trucking business of his own in his home town. One day his job was to haul eight loads of gravel in his truck. It was dusk by the time he started with the last load. He was tired but he decided to take the load any way and complete the job. Just what happened he does not know, but he thinks he drove his truck into another car that was parked without any lights. His gas line broke and his truck went up in flames. What was left of him was taken to a hospital in a near by town where he spent a year or more. He left this hospital and spent several months at home before he entered Presbyterian. When he came to Presbyterian he was gradually becoming blind because he had no eyelids to keep his eyes moist. He had to sit in a darkened room and a radio furnished his first source of pleasure. The radio was splendid as diversion, but he needed something that he could do himself. He learned to crochet rag rugs from old sheets and pillow cases which the hospital allowed him to have. These rugs were well

made and attractive and he had no trouble in selling them. He took orders and executed any color scheme his customers might want. He was moved, in time, from a private room to a ten bed ward, and here he was allowed to run a small store. He kept his supplies in a cupboard built by the hospital carpenter and decorated by the hospital painting department. He dispensed candy bars, chewing gum, shoe laces, stamps and other small commodities. He learned to do basketry and sold his baskets. He saved his money and decided after much thought that he would start a chicken business when he went home. He planned the chicken house he wanted to build and made a drawing of it which only he understood. In the spring he sent money to his mother to buy his first 200 baby chicks. Every one was most kind to him but from the very nature of the case the occupational therapy department acted as liason officer in most of his activities. When he went home, not only had his eyesight been restored but he had been able to buy his own clothes while in the hospital, he had a new radio which he had bought himself, he had bought 200 baby chicks, paid for his transportation home, and had money enough to build the chicken house and start the business which had occupied so much of his time and thought as he made plans for the future.

Twelve years ago the average length of time spent by all patients in general hospitals was fifteen or sixteen days. By improved surgical and medical care this average time has been shortened to approximately nine days. Even nine days can be filled with apprehension and fear, and if no patient ever stayed more than nine days, there would be a wide range of useful and helpful service for occupational therapy. For example, young diabetics from eight to sixteen years of age are constantly passing through the hospital. Their disease may be a recent discovery, or they may have come for further help. It may be necessary to adjust their insulin intake, or to change the type of insulin they use. In any case, the situation may be disquieting at best. Here occupational therapy may fill a very real need if it gives the child a new interest which will tide him over these somewhat abnormal days in the hospital. Often this new source of interest becomes a permanent source of pleasure and profit when the child goes home.

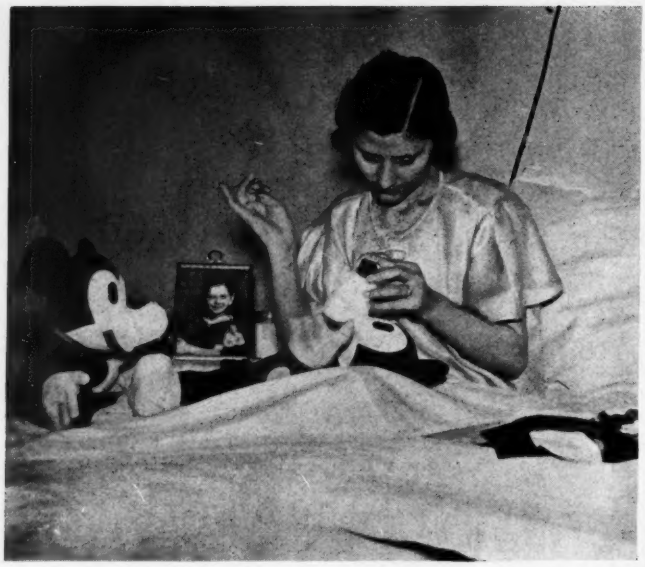
As this article is being written we have in the hospital a diabetic boy twelve years old. He comes from a small town in Michigan where he takes manual training as part of his school work. He enjoys all kinds of handwork and he has always wanted to know how to do leather work, but he has not had an opportunity to find out how it is done. At the present time he has mastered the fundamentals of that craft. He has catalogs and notes to take home wih him and he anticipates with much pleasure how he will teach his favorite cousin to do leather work and what fun they will have doing it. Occupational therapy has taken up the slack, so to speak, in this boy's active mind, and by keeping him busy and happy it has made his treatment easier.

A business man from a city about 200 miles from Chicago is another good example of the contribution an occupational therapy department can make to a short time case. This man came to the hospital for a check-up, expecting to spend one night and to go home the next day. He brought nothing with him: no work, no books. It proved to be necessary for him to stay four or five days.

The boy in the picture on the opposite page cannot leave his wheel chair, but this does not prevent him from doing fine cabinet work.

In the upper picture, play has a therapeutic value for Dick, Norman and Angie.

The lower photograph shows how an occupation diverts the thoughts of the patient confined in an irksome position. Note the look of interest in the eyes.



At the left is shown a convalescent patient who has become interested in making Mickey Mouse dolls.

The patient shown immediately below has had a convalescence which is somewhat longer, but the tedium has been lessened by developing considerable skill in hand weaving.

Below this is shown an undergraduate nurse studying one of the occupational therapy books in order that she may supplement the work of the department.

Our department learned that he was interested in photography. He had been working at it off and on for a year, but he had always sent his films to a professional to be developed and the professional had always made enlargements for him. On further investigation it turned out that our department has the same kind of still camera the patient had, so right away a bond was established. He was interested in our light meter and in our range finder and especially in a book we have which answered many of the questions that had puzzled him. He sent at once for the book and when he went home he had almost decided to try developing and printing himself because we were able to show him how he could get as good results himself as he was getting through the professional. The patient's wife was especially happy about this decision. She confided to us that the doctor had said that her husband would have to give less time to business and more to some gentle art like photography if his condition were to improve.

Occupational therapy may shorten the stay of a patient in the hospital as the following account will show. The patient in this case was a laboring man about twenty-five years old. He fell from a scaffold and fractured two cervical vertebrae by striking the edge of a cement platform when he landed. When occupational therapy was ordered for him he was wearing a high leather collar which kept his head and neck in a rigid position. His left arm and hand hung useless at his side. He could lift his arm by using his right hand to do so. The patient was intelligent and cooperative. After consideration it was decided that braid weaving would furnish the exercise he needed, so a frame of suitable size was made and the patient warped it himself by carrying his left hand around with his right and tightening and fastening the warp with his right hand. He wove with his left hand, five minutes at a time in the beginning. He used short pieces to weave with, and did the beating by turning his left hand wrong side up, lifting it with his right hand, and pounding the weaving into

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Professional Service
IN THE SMALL HOSPITAL

By MACIE N. KNAPP
Normal, Illinois

» » » DR. KILPATRIC of Columbia says "A professor is a vocation by implication gainful, involving the individual, and a considerable body of organized knowledge in self identifying service for others and for the good of society."

A hospital is a most complex organization; its activities are varied and its responsibility grave—so to correlate and coordinate all of the professional groups that enter into the perfect service of a modern hospital, even though it be small, is a colossal task. I wish to state most emphatically, however, that it is entirely possible not only to apply but also to maintain these professional services in the so-called small hospital of one hundred beds.

As I recall, it was our good friend, Matthew O. Foley, who once said that "the small hospital is small only in physical plant and financial resources." In fact, our problems are the same for we are both in the business of mending broken bodies, of removing diseased tissue, of taking a human machine that is out of order and causing it to function smoothly again and continue functioning.

Medical Staff Organization

In the hospital which I am privileged to represent, our medical staff is organized in accordancce with the rules of the American College of Surgeons. The executive committee meets with the superintendent a few days before the staff meeting. Mutual problems are discussed, complete minutes are kept of these meetings and read at the regular staff meeting which is always a dinner meeting, the staff being the guests of the hospital. The actual business is reduced to a minimum and the time spent on matters which relate entirely to the professional care of the patients. The time is divided between the health audit for the month as presented by the record librarian, presentation of cases, and the pathologist who conducts a clinico-patholical conference with specimens, X-ray, slides or moving pictures. Much discussion follows and I honestly believe our staff meetings would compare most favorably with any others. The histories that are incomplete are reported. Friendly contacts are made with these doctors in this regard telling them that their own by-laws say that histories must be complete and up-to-date and in practically every instance the response has been prompt and courteous. Records which used to be a bugbear have actually become a matter of pride, largely because of a most efficient chairman of the medical records committee, and a record room that is well organized.

Fully realizing that perhaps no two departments in a hospital can be so dangerously misleading as the laboratory and X-ray if the work is not carefully done and interpreted, we are fortunate in having secured the services of both a well qualified radiologist and pathologist. The latter performs our autopsies in our post mortem room which has been equipped for that purpose. The percentage of autopsies for the past ten months has been fifteen. All patients have routine blood and urine examinations and all tissue removed at operation is examined.

Of course, there would be no hospital without the doctors and I do not hesitate to say that we are actually blessed with a rather unusual medical staff of men who are progressive, who attend meetings and make definite contributions to their profession and who cooperate in every way to help the hospital maintain a high standard. In fact, they have in several instances made the suggestions which the hospital has been happy to carry out. We like to feel that we are working on a fifty-fifty cooperative basis with our medical staff.

Good Nursing Care

Regardless of all else, our "stock in trade" is still good nursing care, and I firmly believe the school of nursing to be "The Hub of the Hospital Wheel." Quoting Miss Nightingale, "For us who nurse, our nursing is a thing in which, unless in it we are making progress every year, every month, every week, take my word for it we are going back." Our school of nursing, while a part of the hospital, has its own director and one full-time instructor, who teaches the nursing arts. All of our science courses are taught at the local university, as well as physical education. At the present time we have five students who are taking the five year course. We have a four months' affiliation in pediatrics, a two months' affiliation for psychiatry, and one month is spent with the local public health organization.

The case study method of teaching is used with excellent results. The supervising staff of the nursing department holds staff conferences weekly at which time

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Presented at the Tri-State Hospital Assembly May 5, 6 and 7, 1937.

Miss Knapp is superintendent of a hospital of eighty-five beds in one of our smaller cities, so she is qualified to speak of the necessity for maintaining professional standards in the small hospital and of the possibility for doing so.

The Hospital's Function in COMMUNITY ORGANIZATION

» » » THE ORIGIN AND GROWTH of the hospital is a subject which is more or less familiar to those actively engaged in the great work of caring for the sick, and its present status is a source of pride to all those actively employed in hospital service. From a place of refuge for the sick and indigent it has developed to the modern scientific institution which is found today.

Internally, the necessity for convenient and scientific equipment is given universal and practical realization. In the struggle of recent years to maintain this scientific efficiency there has, perhaps, been some neglect of the important feature of community relations. Yet the hospital which is fulfilling its function completely cannot confine itself to the care of the sick who have been admitted. It must extend its influence into the community, promoting hygiene, supporting but not replacing the activities of health departments, seeing that those who have been ill carry on their treatment rationally and effectively during convalescence and taking an active part in every movement directed to the prevention and cure of disease. In short, the hospital is the health center of the community.

Presentation by Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N. Y.

There are two conflicting viewpoints regarding a hospital's responsibility to a community. On the one hand, there are many people who believe that it is merely a hotel for sick people and should be restricted to the business of providing care to patients within its walls. On the other hand, there are many who believe that a hospital should be a community health center and should participate, within the limits of its finances, in various public health activities, with a realization always, however, that it may hinder a community program if it attempts specialized health services without first studying the coordination of such activities with those of other public health and community welfare agencies.

The first obligation of any hospital from the public health standpoint is to set its own house in order. For example, many hospitals are extremely negligent in the examination of hospital personnel and particularly of those who handle food in hospital kitchens and dining rooms. In hospital care of patients, the same principle should obtain. Now that the surgeon general has spurred the campaign against syphilis, hospitals may be persuaded to be more energetic in making the Wassermann test as a routine for all patients.

In the past, many institutions have been too much concerned with their own housekeeping to give thought to other matters in which they should have taken the lead. A particular program may be more dramatic for the moment and may attract more interest than others equally worth while, but if a hospital is to be considered as a health center, it may judiciously extend its activities in more than one direction.

Community Services from the Hospital

Correspondence during the past year with many public health agencies has indicated that there are a number of avenues of public health activity which are open to hospitals. Many of them concern the work of out-patient departments or ambulatory patients. For example, there is the constant war against tuberculosis and other communicable diseases. Care for premature infants in most hospitals is not as well planned as it might be. The number of cancer clinics is growing, but there is still much lack of co-ordination among the various agencies interested in this problem and between these agencies and governmental departments. Advances in the serum treatment of pneumonia have given hospitals an additional opportunity to use their facilities. A twenty-four hour typing service should be available and where not maintained by a department of public health it may be furnished as a service of the hospital not only to its own staff physicians but also to outside practitioners in the community. The modern twins of pneumonia therapy, serum and oxygen, should, of course, be available also.

Agencies concerned with the prevention of blindness point out that hospitals can assist this program not only in observing the best technique in the clinical care of patients, but also in the extension of medical social service work.

These are only a few of the many channels through which hospitals can assist the public health program and in all of them medical social workers can do active missionary work.

Criticism is frequently made that the facilities of hospitals are not made available as they might be for the use of unattached physicians. Many thousands of dollars worth of expensive equipment and the services of highly trained personnel could be used as an aid to diagnosis and treatment of ambulatory patients, outside the hospital. Unfortunately some doctors fear the competition of hospitals with the private practice of medicine, but there is a large and growing section of the medical profession who realize that they would be greatly assisted and the standards of medical practice would be raised if such diagnostic help were made available to them at or near the cost of supplying it.

More attention has been given in the last few years to the need for acquainting the public with the work of hospitals and in most communities there has been some effort to foster educational programs in collaboration with other health agencies or through the medium of hospital councils. The American Hospital Association has made a serious attempt to stimulate the organization of hospital councils in the larger communities and there are a few active and efficient ones. For the most part, however, it

must be said that the results of this effort have been discouraging. The fault may be that hospitals are too individualistic in their attitude, for in most communities there is a lack of team work between individual hospitals.

To digress for a moment, I cannot resist the impulse while here before you to mention the subject of terminology, although I understand you already have discussed it at this meeting. I have many social workers among my friends and I believe that no one could label me as unsympathetic to social service or social service workers. However there are many executives and others who frequently are confused by the foggy polysyllables and the meaningless jargon with which some of you attempt to express yourselves. To illustrate, I quote that definition of social service work which many of you no doubt have already heard and which says that it is "A purposovistic attempt to break down the configurational barriers of erroneous stereotypes and arrive at a valid and integrated evaluation of characteristic folkway phenomena in terms of significant social concepts." The medical profession has often been guilty of cloaking its ignorance with meaningless terms, and I make a plea that social service workers should not attempt to follow such folly. Hospitals have come to recognize their social service departments as indispensable parts of the mechanism of medical care, but I humbly suggest the motor will run smoother if less emphasis is put on Freudian fopperies and pseudo scientific jargon.

Hospital Insurance Plans

The growth of the hospital insurance program in a number of communities in this country during the past few years has given an unusual opportunity to hospitals to demonstrate their important place in the community program, and this is one of the brightest spots on the hospital horizon. Non-profit community hospital plans have brought hospitals together in a joint effort in which is stressed the benefits, first, to the community, secondly, to the medical profession and thirdly, to the hospitals. As Rorem so aptly put it, "Hospital insurance is designed not to put dollars into the hospital budget, but to put hospital care in the family budget." This whole program has smouldered, with occasional bursts of new flame, for over five years, but during the past year it has become an active fire. Over fifty communities now have non-profit and non-commercial plans in operation and over a million people already are covered by hospital service contracts of these plans. The prediction has been made that within the next five years, ten million people will become participants in non-profit hospital insurance plans in the United States. Another prediction is that enrollment under these plans in 1940 will greatly exceed the Farm-Labor Party vote in that year. Whatever be the development, the public has so responded to this opportunity for protection against the financial hazards of hospitalized illness that hospital insurance will become an increasingly important factor in the development of any broad program for community health in this country. As a group, the social workers in American hospitals are in a position to help greatly in furthering this program. I need not tell you how much your assistance, your criticism and your counsel will be welcomed by everyone who is concerned with this latest development in hospital care. Social workers are in the front trenches of any health campaign and have an unusual opportunity both to direct and to interpret a hospital's place in a community program.

Presentation by William J. Orchard, trustee, Orange Memorial Hospital, Orange, N. J.

It is a privilege to be able to discuss briefly before the medical social workers of the American Hospital Association and before the president and members of the American Association of Medical-Social Workers the views of a business man hospital trustee on "The Hospital's Place in Community Organization." Assuredly in the last two generations, there has ben a great extension of public interest in community responsibility; there has been a great extension in the activities and effectiveness of community service organizations of all types. Of late years through the formation of councils of social agencies and other collective groups representing the various phases of community social service activity there has been encouraging progress in bringing about the proper relationship in the activities of the various types of agencies and a wholesome effort has been made to prevent overlapping and duplication of effort. Therefore, it is well that a group such as this will take time to consider and attempt to appraise the place of the hospital in community organization.

From many years of experience in raising funds for community chest purposes and in helping to spend the funds so raised as a hospital trustee, I have reached the definite conclusion that the hospital is the most important agency in community organization; that the hospital plays the largest part in the relation of the public mind towards all community organizations, that the hospital offers the best medium to promote community organization satisfaction and at the same time presents the greatest opportunity for criticism of community organization.

We must realize that in the past two generations the relationship of the hospital to the community has undergone a great change. Your speaker remembers, as though it were yesterday, an occasion just at the turn of the century when, in short pants, he walked to the only telephone in the suburban Massachusetts village where he lived to perform the service for his mother of finding out from the

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That the hospital has an important place in the community organization is becoming increasingly recognized, but the realization of this fact must constantly take a more practical form if the institution is to fulfil its entire responsibility. The discussion of this subject at the annual meeting of the social service section of the American Hospital Association was therefore particularly timely.

Professional Service. . .

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hospital and school problems are discussed and the discussion is followed by a program contributed by members of the staff. Minutes of these meetings are kept on file. Monthly meetings of the entire nursing staff are held at which time reports of the various class meetings and committees are given followed by a program contributed by the members of the staff or outside speakers.

Community Relations

It seems to me that the hospital in the smaller cities play an entirely different part from those in the larger. We are a real part of the community life and ethical presentations of hospital facts are made public from time to time through our public relations dinners or musical teas sponsored by our Women's Service League. It is surely gratifying to see how interested our friends really are in professional standards and how co-operative they are when they or their relatives and friends are admitted as patients.

I often feel that we are particularly fortunate in having such an excellent Women's Service League—it is impossible to put in mere words what this organization means to the hospital. One of their major projects is to renovate and revamp the rooms and under the able direction of the chairman of the house committee a real transformation has taken place. These women are the so-called key women of our community—public spirited and civic minded—and it would be hard to visualize the hospital without their keen interest and cooperative support.

If there should be any one of this audience who has struggled or is struggling with a board or staff on standardization, please take my advice and don't give up, for it is the particular job of the superintendent to educate sometimes both the Board and the staff and always the public as to what standardization really means. If you are honest and sincere in your desire to have your hospital fully approved the day will come when it will be. It may take a long time and you will meet all kinds of opposition, but in the end it is entirely worthwhile and you owe it to your community, to the public you are privileged to serve, to apply and maintain high professional standards regardless of your size.

We know that the very first hospitals were an outgrowth of religion and we all remember that when the Good Samaritan left the half dead man he had picked up on the road from Jerusalem to Jericho with the innkeeper, he said, "Take care of him." The change implied responsibility from sunset until dawn as well as from dawn to sunset. When the hospital admits a patient, the hospital is charged with the same responsibility, and we can only meet this responsibility by maintaining high professional standards.

Finally the only earthly reason for the existence of any hospital is "Service to Humanity," and understanding comes as humanity grows and ripens through service and application.

The story of Florence Nightingale and the story of the modern hospital are inseparable. It is indeed a far, far cry from the hospital at Scutari to the modern, complex hospital with its ever increasing facilities for diagnosis, treatment of disease and provision of the patients comfort and happiness. It is a very old story but one that I believe will bear repetition. It is of the dying soldier in the hospital at Scutari during the Crimean war. His suffering was so great that he prayed God to die, when that patron saint of all nurses, Florence Nightingale, came into the ward, spoke to him, and tried to make him more comfortable. As she left his bedside, the soldier again prayed, not to die, but to live, to be able to see and speak to her again. So down through the years this spirit has been and always will be—The Soul of our Hospitals.

Responsibility for the Medical Record. . .

(Continued from page 16)

which is delegated to the administrative officer. He in turn must institute a system whereby the patients' records are always available for any legitimate use; must have a quantitative and qualitative appraisal and must also require certain reports showing the quantity and quality of the work of individual physicians and of the medical staff as a whole.

To the medical records librarian is delegated the responsibility for the quantitative appraisal and of maintaining the system selected to keep the records available. Only the individual physician and the staff as a whole are competent to exercise medical judgment in a qualitative appraisal and they accordingly must assume that responsibility. Finally from the records thus secured, the medical records librarian is responsible for compiling the required reports.

It is therefore apparent that the nurse, the intern and the attending physician are responsible for completion of the patient's record; that the medical staff, through its organization, is responsible for seeing that this duty is properly performed, taking such action and making such reports as may be required. If any of these do not meet this responsibility, they are derelict in their duty. It is also apparent that the administrator and governing body are equally derelict in duty if they fail to support the work of the subordinate individuals or organization or if they fail to take indicated action on any recommendations received.

Maine Hospital Association

» » The annual meeting of the Maine Hospital Association was held December 17 at the Central Maine General Hospital in Lewiston, Me. The meeting was held in the morning with Dr. Joelle Hiebert presiding.

During the business meeting the constitution and by-laws that had previously been prepared were read and discussed and with the necessary changes were approved and accepted. Fifteen hospitals were represented in the attendance.

The following officers were elected for the ensuing year: president, Dr. Joelle C. Hiebert, Central Maine General Hospital, Lewiston, Me.; vice-president, Dr. Stephen Brown, Maine General Hospital, Portland, Me.; secretary and treasurer, Margaret A. Hebert, R. N., Gardiner General Hospital, Gardiner, Me.

In the News

Hospital Institutes

» » Encouraged by the success of the institutes for hospital administrators which have been held in recent years, the American College of Hospital Administrators has announced its intention to hold institutes in selected centers as a major educational activity. These will be primarily refresher courses designed to broaden the knowledge of those who have already had experience in the hospital field.

The program will consist of lectures, demonstrations of actual procedures in hospitals, panel discussions and round table conferences. Those selected to deliver lectures and to conduct the demonstrations, discussions and conferences will all be men and women who, because of their wide experience, are fully qualified to speak on the working of the department or activity assigned.

The dates and places for the 1938 institutes are not yet announced, but there is no doubt that one will be held at the University of Chicago just previous to the annual convention of the American Hospital Association.

Hospital Directors Hold Meeting

» » The semi-annual meeting of the Board of Directors of the Montana Conference of the Catholic Hospital Association of the United States and Canada, was held at the St. Clare Hospital, Fort Benton, Saturday, November 27.

The Right Reverend Bishop E. V. O'Hara of Great Falls, presided and a tentative program was outlined for the next meeting, which will be held in Missoula, in May 1938.

Fifteen hospitals in Montana are members of the association, which was organized in 1932. The object of this organization is to formulate plans whereby the increased demand for efficiency in the various phases of each department in the hospital may be more effectively carried out by prompt assistance and cooperation with physicians.

East Texas Hospital Ass'n

» » Hospitals of North and East Texas met at Longview on Wednesday, December 8th, and organized the East Texas Hospital Association. The meeting was attended by representatives of the state association who supported the scheme.

Budget Survey

» » Hospitals in Washington that are beneficiaries of either the Federal or District governments will undergo a survey of administration and service at the hands of the Budget Bureau.

There are 13 hospitals which benefit from direct appropriations authorized by Congress. Such institutions as Gallinger, Glenn Dale, Freedmen's, St. Elizabeth's, Walter Reed, Mount Alto and the Naval Hospital receive their entire support from public funds. The others obtain partial support, chiefly special funds for the care of indigents. This new policy of the Budget Bureau is extending to all Federal-controlled hospitals throughout the country.

THE HOSPITAL CALENDAR

Feb. 28—March 3—Association of California Hospitals, Association of Western Hospitals, San Francisco, Calif.
Febuary 14-15—Council on Education of American Medical Association, Chicago, Ill.
March 9—Massachusetts Hospital Association, Boston, Mass.
April 7-9—Southeastern Hospital Association, Birmingham, Ala.
April 14-16—Virginia, North Carolina and South Carolina Hospital Associations Tri-State meeting, Columbia, S. C.
April 18—Mississippi State Hospital Association, Jackson, Miss.
April 21-22—Midwest Hospital Association, Kansas City, Mo.
April 27-29 — Pennsylvania Hospital Association, Pittsburgh, Penna.
May 4-6—Tri-State Hospital Assembly, Chicago, Ill.
May 18-20—New York Hospital Association, Buffalo, N. Y.
May 19-21—Minnesota Hospital Association, Minneapolis, Minn.
June 2-4—New Jersey Hospital Association, Jersey City, N. J.
August 14-16—National Hospital Association, Virginia.
September 23 — American Protestant Hospital Association, Dallas, Tex.
September 25 — American College of Hospital Administrators, Dallas, Tex.
September 26-30—American Hospital Association, Dallas, Tex.
October 17-21—American College of Surgeons, New York, N. Y.

Dionne's Incubator At Wilmington, Del.

» » One of the articles of interest at the opening of the new wing of the St. Francis Hospital, Wilmington, Del., was the incubator that was used by the Dionne quintuplets at the time of their birth. The incubator was placed in the nursery of the maternity ward.

The quintuplets were placed in the incubator shortly after their delivery by Dr. A. R. Dafoe. A plaque on it reads "Loaned to Dr. A. R. Dafoe of Callander, Ontario, for the Dionne Quintuplets."

The incubator is credited with helping to save the lives of the Dionnes. An interesting point is the fact that the incubator was used in the motion picture "The Country Doctor", in which the quintuplets took part.

Tuberculosis Sanatorium Enlarged

» » Formal dedication of a new addition recently completed at the Kehrer Madison County Tuberculosis Sanatorium, Alexandria, Ind., was attended by a number of prominent health authorities in the state.

The new 23 by 45 foot addition at the east end of the hospital will accommodate twelve patients and increases the capacity of the sanatorium to 75 patients.

Medical Clinics Plan San Francisco Fair Exhibits

» » In the huge Hall of Science at the 1939 Golden Gate International Exposition, thirty of America's leading research laboratories will tell the story of the remarkable recent progress which has been made in the prevention and treatment of disease.

Led by such world-famous institutions as the Mayo Clinic, the Jackson Clinic, the American Medical Association, and the American Society for the Control

of Cancer, these laboratories will present a dramatic picture of the latest advances in medicine and its related fields. The exhibit plans will also have the cooperation of the country's leading universities, notably the University of California, Stanford University, the California Institute of Technology, University of Southern California, Harvard University, University of Oregon, and the University of Washington.

Prison Hospital Unsafe

» » The assistant state fire marshal of Ohio has reported to the state fire marshal that the hospital building at the Columbus Penitentiary constitutes a fire hazard and is unsafe.

Dedicate a New Unit

» » St. Francis Hospital, Wilmington, Del., dedicated a new unit Wednesday, December 8th. The new unit is 122 by 42 feet, and is designed to match the old building which was opened in October, 1924. The dedication was conducted by the Most Rev. Edmond J. FitzMaurice, Bishop of the Wilmington Diocese, and was attended by a large number of invited guests.

University Hospital to Expand

» » It has been announced that the WPA has approved the project of expansion for the University Hospital at Augusta, Ga. The program will include a new nurses' home and enlargement of the present one. A new boiler system, laundry and public address system, will also be included in the project. The estimated cost will be in the neighborhood of $200,000.

Change of Ownership

» » A legal contract was signed November 15, 1937, between the Auburn Park Hospital, Inc., Chicago, and the Doctors' Hospital, an Illinois Corporation. The new corporaton will be managed by a board of trustees, consisting of fifteen members, mostly laymen of the community.

Question of Central Council On Nursing Education

» » Following the custom of former years, the Central Council on Nursing Education has arranged a luncheon for lay boards of hospitals and public health nursing organizations, to be held in the Grand Ball-room of the Palmer House, Chicago, on February 14, during the annual meeting of the Council on Medical Education and Hospitals of the American Medical Association. Robert E. Neff, president of the American Hospital Association will be the guest speaker and will take as his subject "Nursing Responsibilities in a Community."

Funds for Naval Hospital

» » An initial appropriation of $1,000,000 for purchase of land and beginning of construction on the new naval hospital at Washington, D. C., will be recommended for inclusion in the 1939 naval appropriation bill according to the annual report to Secretary Swanson.

The project will include facilities for the entire Naval Medical Center, including the hospital, medical school, dental school, technical schools for enlisted personnel, laboratories, power plant and quarters for hospital corpsmen, nurses and a limited number of officers. It will cost around $4,850,000.

Technicians Organize

» » Laboratory technicians of Superior, Wis., met at St. Francis Hospital recently to form an organization to be known as Superior Group Technicians.

Beautifying Hospital Grounds

» » Beautiful grounds will enhance the imposing appearance of the new North Plains Hospital recently opened for formal inspection at Borger, Texas. Grounds about the building have been graded smooth and gently rolling on the south side. New top soil donated by John Weatherly of Panhandle, who also gave the land on which the hospital stands, has been spread immediately around the building for grass sodding, trees, and shrubbery. An expert landscape gardener will be employed next spring to complete the work.

Free Hospital for Clinton, Okla.

» » The State of Oklahoma has purchased the McLain Rogers Hospital at Clinton and will operate it for the care of the indigent sick. The purchase price is reported to have been $115,000 and the state will spend another $5,000 to complete two unfinished wings, bringing the total capacity to 100 beds.

Asks for New Clinic Building

» » Superintendent Elmer E. Matthews of the General Hospital, Wilkes Barre, Pa., is asking the board to provide a new clinic building. In doing so he points out that the majority of clinical activities are being held in a building more than 40 years old. He recommends a building that will house clinics, operating rooms and administrative offices.

At the present these various departments are in different sections of the institution and the operating costs are greater than if all were combined.

Cancer Hospital

» » The State Cancer Commission, Missouri, has selected a site, north of Columbia near Highway 40, for the State Cancer Hospital for indigents. The grounds consist of a 40-acre tract, and $500,000 is available for construction.

Model Hospital

» » Within six months Minnesota's mentally ill will have a new, modern home which Federal authorities declare will be the best of its kind in the country.

Rising on the shore of Moose Lake is a $2,500,000 group of hospitals and dormitories, designed to provide every known convenience for the mentally sick wards of the state.

When the project is completed in May or June there will be 13 buildings on the 1,700-acre site. Seven of the buildings are nearing completion and bids for three others have been asked.

Michigan Building Program

» » The $3,000,000 building program of state hospitals in Michigan will probably commence in the spring. Architects have been engaged and most of them are under contract, but construction plans cannot be prepared immediately. The program is designed not only to provide for present needs but to be elastic for future expansion.

Hospital Twigs an Asset

» » United Hospital twigs, which have long been valuable assets to the hospital at Port Chester, N. Y., rendered especially good service during the hospital's last fiscal year.

The Third, Ninth and Bent twigs donated $700 to the United Hospital Social Department. All twigs combined gave $2,823 to the Board of Managers of the hospital for the purchase of new linen and also contributed 5,792 hospital articles valued at $1,473.66.

New quarters for internes and resident physicians have been provided by renovating five rooms on the fourth floor of the Memorial wing. The cost, $1,947.06 was met by the Second twig. Other miscellaneous gifts brought the total for the year to $17,000.

New Intern Plan

» » A new two-year system for interns at Hurley Hospital, Flint, Mich., is planned to replace the present one-year system. The plan cannot be placed into full effect until July 1, 1939, as thirteen of next July's intern class have already been accepted by the intern committee. Three more will fill the 1938-1939 class.

The new plan will consist of a modified two-year program with the hospital having eight first-year men, eight second year interns and a third-year physician who will be the supervising resident.

From the 1938-1939 class of sixteen first-year interns and two resident physicians, the intern committee will pick eight interns who want to serve the second year and one supervising resident for the third-year physician. The second and third year men will be licensed physicians who want more work.

New Hospital in Alaska

» » Surveys for the foundation of a $100,000 government hospital to be built at Barrow, Alaska, were completed recently. Piles were placed in holes thawed in the frozen earth this fall to permit them to settle with next summer's thaw.

Kansas State Tuberculosis Sanatorium

» » Two Wichita firms have been awarded contracts for plumbing and electrical work on the new 240-bed hospital building at the State tuberculosis sanatorium at Norton, Kansas. Johnson Plumbing and Heating Company was the lowest of four bidders for the plumbing and heating at $30,495, and the Shelley Electric Company was the lowest of nine bidders for the electrical work with a bid of $18,312. W. R. Grimshaw Company of Tulsa was the lowest of ten bidders for the general construction contract.

Work started on the project on December 13, and must be completed within 13 months.

Simplified Practice Recommendation

» » The Standing Committee in charge of reviewing and revising Simplified Practice Recommendation R133-32, Surgical Dressings, has approved the revision of the original recommendation, and has requested that the U. S. Department of Commerce submit it to producers, distributors, users, and others interested in the commodity concerned, for their approval or comment.

Massachusetts State Sanatorium

» » The Westfield State Sanatorium addition, Westfield, Mass., containing 150 beds for adult tubercular patients, was opened recently. The new cancer section has also been completed and opened. This section has 50 beds and except for the one at Pondville is the only state cancer hospital in Massachusetts.

DEATHS

● CHARLES HERBERT LAWALL, M. D., dean of pharmacy at the Philadelphia College of Pharmacy and Science, died of pneumonia December 7 in the Jewish Hospital, Philadelphia. Stricken two weeks before at home with what appeared to be a common cold, complications developed and he was removed to the hospital a few days later. His association with the United States Pharmacopoeia and the National Formulary extended over many years.

Richard Herman Jaffe

● RICHARD HERMAN JAFFÉ, director of the laboratories of the Cook County Hospital and the Grant Hospital in Chicago died suddenly at his home during the night of December 17, 1937.

Professor Jaffé came to Chicago from Vienna in 1923 under an arrangement made with Dr. Charles S. Bacon of the Grant Hospital and at first confined his activities to the organization of the Uihlein Laboratories at the Grant Hospital. This accomplished, he entered into teaching activities as Professor of Pathology in the Medical School of the University of Illinois with unusual success.

His interest centering so largely in the field of gross pathology and the demonstration of morbid anatomy, a number of clinicians who were interested in the Cook County Hospital made a concerted effort to have the position of pathologist finally established there on a properly salaried basis. Up to that time attending pathologists had all acted on a purely voluntary basis. As a result of this demand and particularly the energetic interest of Dr. Louis Schmidt, such a salaried position was finally established by the Cook County Board of Commissioners and Jaffé was appointed director of the laboratories in 1928.

Here, despite many handicaps incidental to difficulties in organization, Jaffé rapidly revealed his great ability as a teacher of physicians. His Thursday morning clinical pathological demonstrations achieved national recognition because of their clarity, the careful integration of the clinical picture with the morbid anatomy that was demonstrated at autopsy, as well as the broad grasp of the clinical problem as it was related to the fields of bacteriology, experimental medicine, etc.

As a result of his work and his influence a definite renaissance of interest in morbid anatomy was created, such as had not existed since the time of Christian Fenger and the recognition of the real clinical value of the pathological laboratory became more evident in hospitals throughout the middle west. Many of his pupils have in turn come to occupy hospital positions in various parts of the United States.

Unselfish, genial, tolerant, and with a delightful sense of humor that can be called truly Vienese, Professor Jaffé gained a wide circle of friends and admirers, who will genuinely mourn his early death. He died at the age of 49 years, survived by a widow and a son.

PERSONALS

● SISTER NOLA, formerly affiliated with St. Joseph's Hospital at Fort Wayne, Ind., has been appointed head of the surgical department of St. Francis' Hospital, Superior, Wis. She is succeeding Sister M. Gabriel who has been transferred to the Loretta Hospital at New Ulm, Minn.

● The appointment of MARY R. MCCARTHY as supervisor of nurses at the Burke Memorial Municipal Hospital, Lawrence, Mass., has been announced. She succeeds the late Mrs. Susan B. Nicholson.

● MRS. DOROTHY BRACKEMEYER has been named general superintendent of the Morrison Hospital, Morrison, Ill., to fill the vacancy caused by the resignation of Irene Irion.

● ROBERT E. ROWLAND, M. D., has been appointed permanent superintendent of the State Hospital, Little Rock, Ark.

● FREDERICK P. MUNDSCHENK has announced his resignation as assistant superintendent of Norwalk General Hospital, Norwalk, Conn. He will become connected with Associated Hospitals Service, New York.

● After more than twenty years of service in the post, MICHAEL ZIMMER has asked to be relieved as warden of the Cook County Hospital, Chicago.

● DOROTHY ROGERS, acting superintendent of the Ellsworth Municipal Hospital, Iowa Falls, Ia., has resigned.

● SISTER MARY BERTINA, mother superior at St. Johns Hospital, Tulsa, Okla., has been appointed mother superior of St. Francis Hospital, Wichita, Kansas, to succeed Sister Mary Agnesina who will replace Sister Bertina in the Tulsa hospital.

● J. H. MARKS, M. D., formerly of Madison, Wis., has been appointed roentgenologist at the New England Deaconess Hospital.

● VERA F. WARNER of Lincoln, Neb., has been appointed director of nursing at Nichols Hospital, Battle Creek, Mich.

● A. D. KINCAID, JR., business manager of the Cabarrus Hospital, Kannapolis, N. C., has resigned his

position to become superintendent at City Memorial Hospital, Winston-Salem, N. C.

● I. ALBERT DURGOM, who has for several years been connected with the Metropolitan Life Insurance Co., has been appointed executive director of the Hospital Service Plan of New Jersey.

● HORACE LOGRASSO, M. D., superintendent of J. N. Adam Memorial Hospital, Perrysburg, N. Y., was eulogized as a "torch bearer for Italian-American physicians" at a dinner honoring him for his 25 years of service at the Perrysburg institution. The dinner was given in Hotel Statler by the Baccelli Club, Italian-American Medical Society.

● COL. ORVILLE D. WESTCOTT, manager of the Muskogee Veterans' Hospital, Muskogee, Okla., has been transferred to the Veterans' Hospital at Walla Walla, Wash. Frank S. Cleckler will succeed Col. Westcott at Muskogee.

● R. S. ANDERSON, M. D., who has been appointed superintendent of the Erie County Tuberculosis Hospital, Erie, Pa., has been assistant superintendent of the Michigan State Tuberculosis Hospital at Howell, Mich., for the past several years.

● MRS. MARGUERITE BAUMGARTNER of Milton, has accepted the position of superintendent of nurses at the Muncy Valley Hospital, Muncy, Pa. She succeeds Miss Margaret Bower, superintendent of nurses at the Muncy Hospital for four years, who leaves to assume a similar position at the Corry City Hospital.

● RUTH CORT has been appointed acting superintendent of Latrobe Hospital, Latrobe, Pa., succeeding Amy Linsenmayer, who died recently.

● ELIZABETH A. GALLERY, R. N., present superintendent of the Greenville Hospital, Waynesburg, Pa., has been chosen as superintendent of the new Green County Memorial Hospital.

PROJECTS

● Construction work on the proposed $200,000 building for tuberculosis patients at Kalamazoo State Hospital, Kalamazoo, Mich., will be started early in the spring, it has been announced by the medical superintendent of the hospital. Meanwhile detailed study of the requirements for the building with definite considerations for future addition will be made.

● An increased tax levy of 15 cents on each $100 property valuation for proposed construction of a tuberculosis sanatorium was provided for in the annual appropriation budget adopted recently by the St. Clair County, Mo., Board of Supervisors. The 15-cent levy will provide $585,000 for the purchase of a site and construction of the sanatorium.

● Construction of a $270,000 patients' wing at the Western North Carolina Tuberculosis Sanatorium, Black Mountain, N. C., will start soon.

● Contracts for the erection of a third floor addition to the Stewart Building at the State Tuberculosis Sanatorium, four miles southwest of Little Rock, Ark., have been awarded to Fayetteville, Russellville and Morrilton contractors.

● The City of Clarksville, Ark., will ask bids on the construction of a $45,454 hospital; a PWA grant is available. The building will be two stories high, 41 by 92 feet, and will contain nurses' quarters, offices, private rooms, wards, kitchen, dining room, chapel, emergency room, utility rooms, linen room, operating rooms and X-ray rooms.

● Oakland Park Hospital Association, Jacksonville, Fla., has purchased from the Somerset Company the property which the hospital occupies, consisting of three buildings and a large corner lot. Members of the association's board of directors are formulating tentative plans for remodeling the main building and enlarging it to more than double the present hospital accommodations.

● Plans and specifications for the new addition to the Perry Memorial Hospital in Princeton, Ill., are in the hands of contractors and bids were opened at a joint meeting of the mayor and city council with the trustees of the hospital.

● Bids for the new criminal insane ward building at the Larned State Hospital, Larned, Kansas, have been opened by the state board of administration. The state legislature last winter appropriated $192,500 for the building and recently Governor Huxman secured a PWA grant of $157,500 from the Federal government, which makes a total of $350,000 available for the Larned project.

● Bids have been called for construction of an addition to SS. Mary and Elizabeth Hospital, Louisville, Ky. The improvements will include an obstetrical department on the first floor, 19 private rooms with baths, delivery rooms, sterilizing room, emergency room and utility room. The second and third floors, which are to connect with the present building, will contain private rooms, treatment rooms, etc. The fourth floor will house an extension to the operating department. The building will be fireproof and the estimated cost of the program is $125,000.

● At Charleston, W. Va., the State Board of Control received bids for the construction of a hospital unit at Denmar Sanatorium, the tuberculosis sanatorium for negroes. The total cost is estimated at $267,000; a PWA grant of $120,150 is available. The new 100-bed unit will contain offices, operating rooms, X-ray department, nurses' quarters; center portion to be three stories, remainder two stories.

● Dr. and Mrs. W. L. Vickers have purchased at Bowling Green, Ky., a portion of old Southern Sanatorium which they will convert into a private hospital to accommodate 20 beds. Extensive remodeling is already under way.

● The board of directors of Memorial Hospital, Longview, Texas, plan the construction of a $12,000 Gregg County health unit building on grounds adjoining the hospital.

● The State Board of Control of Texas, has plans nearing completion for $127,000 psychopathic building at the Rusk State Hospital. The building will be two stories in height, 180 x 100 foot with terrazzo and tile floors.

● The Erlanger Hospital Building Committee, Chattanooga, Tenn., has received bids for the construction of a hospital building for the City and Hamilton County. Of the $951,016 available, $490,000 has been allotted by a PWA grant; the remaining amount will come from city and county funds. The building will be seven stories high; the major operating rooms will be air-conditioned and an addition is planned for the nurses' home.

● The State Board of Control, Charleston, W. Va., has received bids for the construction of a $400,000 hospital building at Pinecrest Sanatorium. The building, which is to be three stories high, will contain offices, X-ray rooms, kitchen and dining room.

● Morgan County Court has received bids for construction of $35,000 addition to the Crippled Children's Hospital, known as "The Pines." A wing addition to the present building, additions to dining room and rear of headquarters to be used as a school, are planned.

● The county board of Walworth County, Wis., has voted to build a $175,000 hospital building at the county farm two miles east of Elkhorn.

● The Board of Administrators opened bids January 4 for the construction of auxiliary buildings for the new Charity Hospital of Louisiana at New Orleans.

● The board of trustees of North Carolina Orthopedic Hospital, Gastonia, have awarded a general contract at $48,653 to R. H. Pinnix of Gastonia, for an isolation and admission ward.

● A contract has been let for the construction of a two-story addition to the H. F. Long Hospital at Statesville, N. C., which will increase the capacity of the hospital to 65 or 70 beds.

● R. E. Bushong, superintendent of the Lima State Hospital for the Criminally Insane, Lima, Ohio, has announced that a $26,725 WPA grant would be used to erect a third story on a wing of the hospital.

Dietary and Food Service

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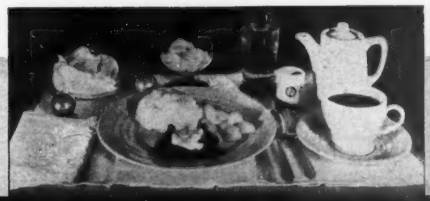

DIETARY AND FOOD SERVICE

MARGARET ROSENMEIER
Dietitian, Henrotin Hospital, Chicago, Ill.
EDITORIAL DIRECTOR

SILVERWARE – IT'S PURCHASE AND CARE

By MARGARET ROSENMEIER
Dietitian, Henrotin Hospital, Chicago, Ill.

» » » ANY HOSPITAL or institution executive director appreciates the value of fine silverware and the importance of its proper care. No one item in the service of food reflects good care as does the silverware, either flat or hollow. In fact, in this country, clean, beautiful silverware is usually associated with good service and good food.

Qualities of Flatware

Flatware is made with an 18 per cent nickel silver base. It is cut out of stock, graded and rolled until it is the corresponding size of a spoon or fork. It is then placed in various presses and the spoon bowl or fork tines are shaped and struck with the pattern die. The edges are trimmed and smoothed down so that the article resembles the finished product. The item is then cleaned, polished and prepared for plating. Unplated silver, known as nickel silver, is sometimes sold to such institutions as prisons and lumber camps, but it is unsatisfactory as the metal discolors easily and absorbs grease and oil.

The actual plating process is accomplished by electrolysis. The article to be plated is hung in a solution and the silver is deposited on it, the thickness of the silver depending on the length of time the article stays in the solution. There are numerous qualities of silverware and the size and type of institution should determine the quality to be purchased.

In the manufacture of knives a different problem is met. Formerly a steel base was used, for if 18 per cent nickel silver were used, two difficulties would have been encountered: first, the blade would have bent easily; second, the edges would have been too dull for practical use. The first knives were plated on crucible steel and these are still referred to as 12 dwt. However, they are rapidly disappearing from service in this country. They are not recommended since the steel base absorbs moisture through the plate, causing rust and eventually peeled plate. As the plate wears off, the base metal appears black and unsightly.

Stainless steel blades have been developed within the past few years and are now commonly used. By combining the stainless steel blade with the 18 per cent nickel base handle, a piece of merchandise which meets every requirement of appearance and service is obtained.

In the development of the plating industry certain standards have become known to the manufacturers and to the trade. Triple Plate indicates that six ounces of pure silver have been applied to one gross of teaspoons with other items in proportion; tablespoons call for twelve ounces of silver to the gross. Competition has caused manufacturers to place on the market a five-ounce plate which one would think means five ounces of pure silver to the gross of teaspoons. Unfortunately, this standard calls for five ounces of silver to the gross of tablespoons, or 2½ ounces to the gross of teaspoons. Today it is proper to refer to five-ounce plate as Full Standard and half plate as Half Standard.

It was found that the wear of a spoon or fork could be lengthened if the parts where heaviest wear occurred were given extra plating. Thus, the backs of the bowl of the spoon, the fork tines, the knife handles get an extra coat of silver. This additional plating is referred to as overlay, sectional plate and reinforced plate. Practically all of the commercial grades on the market are made with this additional plating at one or more points of wear.

Purchase of Holloware

In buying holloware it is always best to buy the best grade because of the severe usage to which it is subjected. The grade that is standard with all of the better known manufacturers is known as nickel silver, silver soldered hotel ware. The base metal used is identical with that used for flatware. After the body of the piece has been shaped by dies and the various parts are made, a skilled silversmith assembles the parts by hand. Only silver solder is used. As an illustration, the number of separate parts used in the manufacture of a coffee pot are: body, base ring, center mount, top mount, two pieces for handle, cutting handle and soldering insulate, two pieces for spout, two pieces for reinforcing spout, two pieces for hinge, bezel in cover, cover, tip.

The top mounts are nickel silver wires carrying a design. They are soldered to the body of the piece for two purposes: first, decoration; second, to strengthen the outer

Attractive silver not only adds to the appearance of the tray, as illustrated in the departmental cover page, but also it is a definite economy if the silver is properly controlled to prevent loss. The plating should be of good quality and the design should be pleasing in character. A complicated pattern adds to the difficulty of cleaning and polishing. Photographs, courtesy Presbyterian Hospital, Chicago.

edge or to absorb blows on the side. These mounts are essential to every item and should be considered when holloware is selected. Many items are made without mounts for the sake of economizing in price.

Holloware is sometimes made of soft soldered construction in place of hard or silver solder. This will not resist heat even in the oven. It will not hold and the spouts and tips will easily break off. Sometimes holloware is made of a base metal referred to as hard white metal or Britania metal. This white metal is very soft and will melt easily. This kind of holloware is very inexpensive, but it will probably be damaged the first day in service.

In selecting holloware it is well to bear in mind the following points:

1. Avoid items with sharp corners. Look for rounded bottoms in coffee pots, creamers, etc.
2. Examine the type of insulating in handles of articles to be used for hot liquids.
3. Short spouts are sometimes preferable to long spouts as they are cleaned more easily.
4. Be sure that the thickness (gauge) of the base metal is ample to insure strength required in the piece.

Care of Silverware

The greatest abuse of silverware comes from its being handled by inexperienced help. As soon as silverware is used it should be placed carefully in hot water of at least 160 degrees Fahrenheit. If the water contains lime it must be neutralized with a water softener as the lime leaves a white deposit which is difficult to remove. It is important that the dishwasher be absolutely clean and free from grease.

Silverware tarnishes quickly. The tarnish is an oxide formed on the surface of the metal by gas leaks, sulphur, rubber, grease, smoke, etc. In one cafeteria it was found that the paper napkins in which the silver was wrapped contained 48 per cent sulphur. It is no wonder that the silver turned black. Another hotel reported that in spite of regular cleaning, the silver was always black. It was discovered that a large pulp mill was located about a mile from the hotel and the blower in the mill threw a sulphide

into the air. An intake fan in the hotel drew the sulphide particles in and when the fans were turned off in the evening, the particles settled on the silverware. Egg yolk and rubber bands are two more offenders when it comes to tarnish. Rubber floor mats near the dishwasher cause a great deal of trouble, as the particles of sulphide are thrown into the air when people move on the mats. Many people have been known to dip silverware in empty butter and lard tubs. These tubs are usually made of pine which contains considerable resin. The resin dissolves in hot water and when it cools it leaves a precipitate on the silver causing white spots to appear.

Contrary to a common idea, burnishing does not remove tarnish. Silver must be thoroughly cleaned and detarnished before it can be put in the burnishing machine. The following method accomplishes this:

First, be sure that there is ample boiling water available. Place the silver in a wire basket and immerse it in a solution of boiling water and cleaning compound that contains tri-sodium phosphate. An aluminum vessel is preferrable but if this is not available it is essential that a piece of aluminum or zinc be placed in the bottom of the container so that the silver touches it. This creates a mild electrolytic action; the tarnish (oxide) forms a salt with the aluminum and the tarnish is removed. The cleaning compound also cuts and dissolves the grease and dirt. Next, rinse the silver in boiling water and place it in the burnisher. Be sure that there is plenty of shot in the burnisher and that it is not overloaded.

Study the soaps used in washing silverware. Many contain resin. Often a black deposit can be wiped off a piece of silverware with a napkin. This is brought about by caustic soaps or by leaving the silver in the cleaning solution too long.

As has been said before, a clean silver service creates an atmosphere that institution directors strive for—it stamps character by its appearance, design and quality. However, many directors hesitate to buy it because of the danger of loss and theft. It is one of the most economical forms of service there is if it is properly cared for and checked. It is interesting to note that the average replacement af silverware is about 10 per cent annually including flatware and holloware. To insure the minimum of loss the following precautions should be taken:

1. Check your employees. Where is your surplus stock carried? Who is responsible for it? Is it locked up?
2. Check your garbage.
3. Check your room and tray service and return.
4. Try weighing your silverware daily. It is quicker than counting.
5. Keep an accurate inventory and let your employees know it.
6. Make your employees responsible for the silverware they handle.

"Food for Fifty"

» » "Food for Fifty" by Fowler, Sina Faye and West is a valuable addition to the library of any dietitian. It contains many tested recipes, tables and meat charts, and suggestions for menu planning. The list of foreign terms used in writing the menus is of interest also. This book is published by John Wiley and Sons, Inc.

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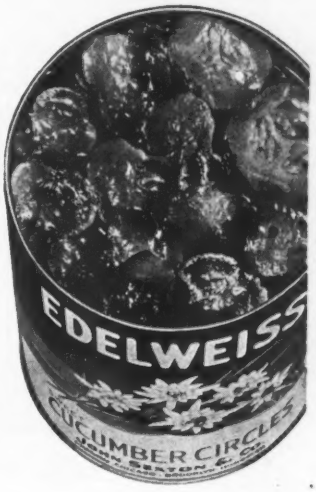
—GEORGE WASHINGTON
1st President of the United States



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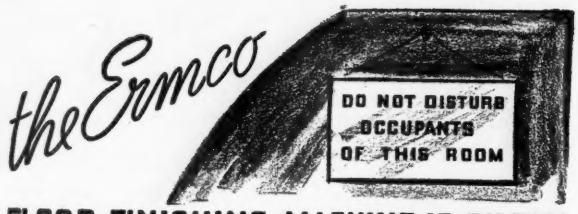

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Food Prices Show Slight Decrease

» » November food purchase prices decreased .94 per cent as compared with October, 1937, price levels, according to the latest Grinstead Food Price Index, compiled monthly by R. M. Grinstead & Co., Inc. The November index was 126.57 as compared with 117.82 in November of a year ago, being an increase of 7.43 per cent this November over last.

The Index is based on current prices paid by a selected list of institutions to purveyors. It comprises prices actually paid for approximately one hundred articles of food, weighted according to the proportion of these different foods purchased each month, thus compensating seasonal fluctuations in consumption.

All food groups, except vegetables, salads and dairy products decreased from October levels. However, all groups except fish, vegetables and dairy products are still considerably above November 1936 levels. While meats decreased 4.44 per cent in November, they are 20.31 per cent above last November's index. Poultry decreased .45 per cent this month from October's high point. Fish and seafood decreased .13 per cent from October and was 1.19 per cent below November, 1936. Vegetable costs increased .37 per cent this month, but were 11.16 per cent under a year ago. Salads, fruits and groceries are all above last October, while dairy products are 8.12 per cent lower despite an increase of .73 per cent this month.

Evaluating the weighted average of food prices paid in January, 1934, at 100, the course of price changes has been as follows:

January, 1934	100.00
November	117.82
December	118.15
January, 1937	122.12
February	121.63
March	123.89
April	122.44
May	121.04
June	120.77
July	124.61
August	124.71
September	129.44
October	127.77
November	126.57

The following table shows in percentages, the average change in November from the preceding month and from November, 1936. The proportion of the main food groups purchased last month is shown in percentages of expenditures.

Prices paid in November, 1937, compared to:

	Oct. 1937	Nov. 1936	November, 1937 Percentages of Expenditures
Meat	−4.44%	+20.25%	26.68%
Poultry	− .45	+12.75	12.06
Fish	− .13	− 1.19	8.11
Vegetables	+ .37	−11.16	6.03
Salads	+9.12	+ 8.16	2.36
Fruit	−2.62	+ 8.08	3.81
Dairy Products	+ .73	− 8.12	24.97
Groceries	− .53	+ .50	15.98
Change on Total (Weighted)	− .94%	+ 7.43%	100.00%

Keep track of price changes by watching this Index, which appears every month exclusively in HOSPITAL MANAGEMENT.

GENERAL MENUS -- FEBRUARY

Suitable for Staff, Personnel and Patients Not Requiring Special Diets

Breakfast	Dinner	Supper
	Tuesday, February 1	
Orange Juice Bacon Pettijohns Eggs Crumb Coffee Cake	Breaded Veal Cutlets Mashed Potatoes Hubbard Squash Pineapple in Lime Jello Date Nut Torte	Chicken Souffle Potato Chips Cooked Vegetable Salad Stuffed Baked Apple
	Wednesday, February 2	
Stewed Pears Cream of Wheat Bacon Eggs Toast	Lamb Patties Parsley Potato Balls Broccoli with Hollandaise Sauce Mixed Fruit Salad Strawberry Ice	Vegetable Plate Lima Beans, Bacon Spinach Baked Sweet Potato Cottage Cheese Salad Baked Custard
	Thursday, February 3	
Stewed Raisins Bacon Oatmeal Eggs Clover Leaf Rolls	Beef Roll Prabant Potatoes Broiled Tomato Head Lettuce Salad Russian Dressing Lemon Snow with Cherry Sauce	Canadian Bacon Fried Apples Buttered Hominy Vegetable Salad Chocolate Cake with Chocolate Sauce and Whipped Cream
	Friday, February 4	
Apricots Ralstons Bacon Eggs Toast	Broiled Blue Fish with Tartar Sauce Mashed Potatoes Harvard Beets Asparagus Salad — Vinigrette Dressing Dutch Apple Cake	Fresh Shrimp Omelet Stuffed Baked Potato Peas Head Lettuce Salad Ambrosia
	Saturday, February 5	
Prune Juice Bacon Wheatena Eggs Toast	Corned Beef Whole Boiled Potatoes 7-minute Cabbage Mixed Fruit Salad Pumpkin Custard	Creamed Dried Beef on Muffets Steamed Rice Molded Vegetable Salad Blue Plums Sugar Cookies
	Sunday, February 6	
Orange Sections Puffed Rice Bacon French Toast with Jelly	Chicken a la Maryland Hominy Grits Peas & Onions Frozen Cream Cheese Salad Peppermint Ice Cream	Cream of Fresh Mushroom Soup Fruit Salad Hot Rolls Butterscotch Brownies
	Monday, February 7	
Grapefruit Juice Bacon Dynamite Cereal Eggs Toast	Roast Lamb, Mint Jelly Mashed Potatoes String Beans Stuffed Prune Salad Chocolate Tapioca	Creamed Peas in Baked Custard Squash Broiled Tomato Stuffed Celery Angel Food Cake with Ice Cream
	Tuesday, February 8	
Peaches Cream of Rice Bacon Eggs Date Muffins	Baked Pork Tenderloin Noodles au Gratin Chopped Spinach Cinnamon Apple Salad Cottage Pudding with Nutmeg Sauce	Individual Meat Pie with Vegetable Spiced Fruit Salad Floating Island
	Wednesday, February 9	
Nectarines Bacon Pettijohns Eggs Toast	Stuffed Breast of Veal Steamed Potatoes Creamed Asparagus String Bean Salad Cherry Cobbler	Hot Chicken Sandwich Potatoes Chopped Vegetable Salad Sliced Oranges and Bananas
	Thursday, February 10	
Tangerines Bacon Ralstons Eggs Corn Bread	Liver Bernaise Au Gratin Potatoes Fresh Wax Beans Stuffed Fig Salad French Caramel Custard	Asparagus on Toast with Cheese Sauce Bacon Curls Devilled Egg Salad Baked Rome Beauty Apple
	Friday, February 11	
Apricots Bacon Oatmeal Eggs Toast	Salmon Croquettes Cream Peas Baked Potatoes Brussels Sprouts Pear Salad Lemon Cream Pudding	Poached Egg in Rice Ring Spinach Celery Hearts and Olives. Vanilla Blanc Mange
	Saturday, February 12	
Prunes Bacon Mead's Cereal Eggs Toast	Prime Ribs of Beef Franconia Potatoes Creamed Cabbage Chopped Vegetable Salad Nabisco Ice Box Cake	Broiled Sweetbreads & Mushrooms Stuffed Sweet Potatoes Lettuce Salad Pineapple, Marshmallow, Banana Fruit Cup
	Sunday, February 13	
Grapefruit Juice Bacon Maltex Eggs Bran Muffins	Roast Turkey with Cranberry Sauce Mashed Potatoes Diced Carrots Spinach and Cauliflower Salad Macaroon Ice Cream	Eggs a la Goldenrod Rice Croquettes with Jelly Spiced Beet Salad Angel Food Cake
	Monday, February 14	
Stewed Cherries Bacon Cream of Barley Eggs Toast	Lamb Roll Mashed Potatoes Broccoli with Pimiento Valentine Gelatin and Pineapple Salad Strawberry Whip	Sauted Chicken Livers Baked Potato Cooked Vegetable Salad Heart Cakes
	Tuesday, February 15	
Sliced Bananas Bacon Corn Flakes Eggs Coffee Cake	City Chicken Creamed Potatoes Romaine Mixed Fruit Salad Maple Nut Cream Pudding	Manhattan Roll Vegetable Gravy Baked Squash Waldorf Salad Norwegian Prune Pudding

HOSPITAL MANAGEMENT'S DIETARY AND FOOD SERVICE DEPARTMENT

GENERAL MENUS FOR FEBRUARY

Continued

Breakfast	Dinner	Supper
Wednesday, February 16		
Tomato Juice Bacon Cream of Rye Eggs Toast	Broiled Ham, Pineapple Delmonico Potatoes Cauliflower Lettuce Bread Pudding	Veal Fricasse Boiled Macaroni String Bean Salad Fruit Cup Sugar Cookies
Thursday, February 17		
Prunes Ralstons Bacon Eggs Sweet Rolls	English Mutton Chops Parsley Potato Balls Julienne Beets Endive Salad Butterscotch Tapioca	Pickled Tongue with Fruit Sauce Stuffed Baked Potato Bishop's Bread Chopped Cabbage and Carrot Slad
Friday, February 18		
Apricots Cream of Wheat Bacon Eggs Toast	Broiled White Fish Whipped Potatoes Fresh String Beans Tomato Aspic Salad Apple Betty	Escalloped Crab Meat in Casserole Steamed Rice Lettuce, Roquefort Dressing Seedless Grapes
Saturday, February 19		
Pineapple Juice Wheaties Bacon Eggs Toast	Baked Beef Tenderloin Au Gratin Potatoes Julienne Carrots Pear, Cottage Cheese Salad Chocolate Tort	Lima Bean Loaf with Grilled Bacon Chopped Spinach Cole Slaw Raggedy Ann Peaches
Sunday, February 20		
Half Oranges Pettijohns Bacon Eggs English Muffins	Roast Duck, Pecan Dressing Mashed Potatoes Broccoli, Hollandaise Sauce Mixed Fruit Salad Chocolate Chip Ice Cream	Broiled Fresh Mushrooms on Toast Sweet Potatoes and Apple Head Lettuce Salad Filled Cookies
Monday, February 21		
Apple Sauce Oatmeal Bacon Eggs Toast	Leg of Veal, Gravy Whole Boiled Potatoes Cauliflower Polonaise Perfection Salad Apricot Whip	Cheese Omelet with Broiled Tomato Stuffed Baked Potato Cooked Vegetable Salad Canned Strawberries
Tuesday, February 22		
Half Grapefruit Omar Cereal Bacon Eggs Breakfast Rolls	Broiled Liver, Bacon Escalloped Potatoes Frozen Wax Beans Banana Salad Cherry Blanc Mange	Chicken a la King in Chinese Noodle Ring Fresh Peas Cinnamon Apple Salad Sand Tart
Wednesday, February 23		
Apricots Shredded Wheat Bacon Eggs Toast	Leg of Lamb Mashed Potatoes Creamed Chopped Spinach Pear and Currant Jelly Salad Pistachio Ice Cream	Meat Stew with Vegetables on Baking Powder Biscuits Mixed Fruit Salad Floating Island
Thursday, February 24		
Sliced Oranges Wheatena Bacon Eggs Popovers	Swiss Steak Franconia Potatoes Stewed Tomatoes Green Salad Sponge Cake	Baked Squash Stuffed with Diced Potatoes and Bacon String Beans Cottage Cheese Salad Peeled Nectarines
Friday, February 25		
Figs Cornmeal Bacon Eggs Toast	Poached Halibut with Egg Sauce Mashed Potatoes Harvard Beets Head Lettuce Salad Snow Pudding	Escalloped Oysters with Tartar Sauce Baked Potatoes Asparagus Salad Baked Apple
Saturday, February 26		
Prunes Cream of Wheat Bacon Eggs Toast	Baked Ham with Raisin Sauce Whipped Sweet Potatoes Peas Pineapple Tid Bit Salad Tapioca Cream	Baked Creamed Macaroni with Dried Beef Chopped Salad Bowl Fruit Compote
Sunday, February 27		
Canned Grapefruit Ralstons Bacon Eggs Crumb Muffins	Fricasse of Chicken Mashed Potatoes Brussels Sprouts Tomato Salad Butterscotch Ice Cream	Corn Chowder Frozen Fruit Salad Hot Rolls Jelly Lady Baltimore Cake
Monday, February 28		
Sliced Bananas Oatmeal Bacon Eggs Toast	Pot Roast with Carrots Mashed Potatoes Water Cress Salad Peach Cobbler	Spaghetti a la Creole Mixed Vegetable Salad Chocolate Pudding

Chart for Selection and Preparation of Chicken

Chickens under one year old (tender meat):

1 to 2½ pounds (either sex). Characteristics: young, soft-meated. 8 to 10 weeks old. Amount to be served per person: one-half bird. Method of cooking: roasting, frying or broiling. Common market term: broiler.

2½ to 3½ pounds (either sex). Characteristics: differs from above in size and age. 14 to 20 weeks old. Individual portion: ¾ to 1 pound. Method of cooking: roasting, frying or broiling. Common market term: fryer.

Over 3½ pounds (either sex). Characteristics: tender, soft-meated, keel bone flexible. 5 to 9 months old. Individual portion: ½ to ¾ of a pound. Method of cooking: roasting or frying. Common market term: roaster.

4 pounds and over (unsexed male). Characteristics: tender, soft-meated. 7 to 10 months old. Individual portion: ½ to ¾ of a pound. Method of cooking: roasting or frying. Common market term: capon.

3½ to 5½ pounds (young hen). Characteristics: tender, keel bone flexible. 4 to 9 months old. Individual portion: ¼ to 1 pound, depending upon the method of cooking. Method of cooking: all methods. Common market term: pullet.

Chickens one year and over (less tender meat):

2½ pounds and over (female) (old hen). Characteristics: less tender, keel bone is hard. Individual portion: ¼ to ½ pound. Method of cooking: fricaseeing, simmering, steaming or stewing. Common market term: fowl.

3 to 6 pounds (male). Characteristics: darkened and toughened meat. Individual portion: ¼ to ½ pound. Method of cooking: simmering, chiefly for soups. Common market term: cock.

Dilutant for Orange Juice

» » A dilutant for orange juice that will not make the natural juice taste artificial and will not lower the nutritive value of the orange juice has made its appearance on the market.

It is Vitamin C Fortified V-C-B Base produced by Hilker and Bletsch of Chicago, Cincinnati and St. Louis. The cost of one gallon of V-C-B Base is about fifty cents which, when mixed with an equal amount of pure orange juice, cuts the cost of the orange juice considerably. This Base has the additional value of not turning sour on standing. In fact, it is said to aid in maintaining the flavor of fresh orange juice even when it has stood overnight. One half ounce of Fortified V-C-B Base, dissolved in four ounces of water, contains approximately 50 mg. of vitamin C or 100 International Units.

Soft Kurd Milk

» » Increased use of soft kurd milk has brought renewed enthusiasm for the product. Soft Kurd Milk (a mineral-modified milk) is pure, fresh pasteurized fluid milk, treated by a special scientific process which makes the milk more digestible. The salts are rearranged so that the milk stays liquid during digestion. Many patients not able to tolerate regular milk find they can take this product. It is processed by local dairies under the supervision of the M & R Dietetic Laboratories, Inc.

Selection of Personnel. . .

(Continued from page 21)

chosen must offer a challenge to him, take the measure of his abilities, and find him adequate. If the superior individual is put to doing routine tasks, he is likely to seek another position and it will soon be necessary to train some one else to take his place. When routine positions are used to prepare individuals for work on higher levels, they must be recognized as temporary, with promotions granted in due time, or some other organization will secure the benefit of the training which has been afforded. An unduly high rate of labor turnover may be accepted as inevitable, but it may be increased by improper selection. In fairness to the organization as well as to the individual himself it is important to recognize that the qualifications of the individual should not be very superior to those required for the position in which he is to be placed, particularly a routine position. This must be instilled in the employment philosophy of the department heads, because one of the great sources of loss during the recent troubled economic period was from placing superior persons in inferior positions. This represented a waste of their efforts which was costly not only to them, but to the organizations for which they worked and which did not realize the proper returns from their services because of not giving them suitable work to do.

Economic Considerations

The problems presented by financing a hospital, which, of course, are particularly acute during a time of economic disturbance, have gravely interfered with maintaining hospital organizations and handicapped the administrator in selection. For this reason, if for no other, the hospital administrator must seek to obtain on the part of employees the altruistic attitude which is accepted as the chief principle in the philosophy of the professions primarily entrusted with the care of the sick-doctors and nurses. That most precious of all commodities, human life, is dependent upon the proper functioning of the hospital so that it renders the best possible health care. Members of the personnel who do not come into direct contact with the sick are not likely to gain a proper appreciation of this fact without it being explained to them. The administrator and persons working under him in key positions may not realize the importance of aiding all employees to gain an understanding of the relation of their work to human welfare and that they are really performing a task vital to life and health, notwithstanding the fact that their work is formally that of supply clerk, dining room girl, cook, or laundryman, for example.

The hospital administrator in certain instances has been faced with the problem of labor organizers intervening in employment problems. He may not realize that the basis for labor organization is a social philosophy, just as the basis for the health organizations in a social philosophy. The two philosophies should not be antagonistic. The tenets of the philosophy of organized labor place emphasis

upon the employee's rights in connection with his job, the rights most often claimed for him by the organizer being to designate some one to represent him and his fellow workers officially in order to secure for them what they very naturally desire, more compensation, possibly less work and better working conditions.

Being engaged in humanitarian work, hospital authorities should recognize better than any one else the importance of adequate compensation, of making no greater demands upon employees than are fair, and of providing the best possible working conditions. He must realize that if he does not solve the problems of financing his institution so that employees are paid adequate wages, he will lose their services and cannot replace them with competent workers because other positions will be more attractive. In an emergency, to meet especial demands for health care, inadequate compensation and excessive work may be necessary, but this must be only temporary and offset later.

Imparting this point of view to candidates for employment before they are hired, choosing those who are socially-minded and realize the obligations of the position so that they will always consider the sick first, is very important. This is necessary especially in the present day, when the importance of health and care may be overlooked—as it nearly always is by the general public when well—while discussions grow heated in favor of, or against the use of force as a means of obtaining social justice for workers.

Occupational Therapy. . .

(Continued from page 24)

place with the left hand. In a few days he could move his fingers. By the end of four weeks he could lift his left arm and hold a cigarette with it. The doctor was so pleased with this progress that he allowed the patient to go home two weeks earlier than the patient had hoped to go, but with the provision that the braid weaving would go with him and the good work would be continued.

Last summer a young school teacher started to drive from the southern part of Illinois to northern Wisconsin where her sister has a summer home. She did not feel very well when she started, and by the time she reached Chicago she felt so much worse that she decided to come to the hospital where she had been a patient before. An old digestive difficulty had flared up and it was a matter of staying in the hospital until the trouble quieted down and her diet could be regulated. She was very much disappointed at having to postpone her trip but she was philosophical and she looked about for something to do. She was familiar with the occupational therapy department and it took her but a short time to decide to make a guest book for her sister's summer cottage. Designing the book and making it filled all her spare time and when she left she said, "Well, it wasn't so bad after all. Sister will love the book."

Any single case I have mentioned in this article would have lived without occupational therapy. If adequate care of patients is the aim of our general hospitals, it is perhaps not too presumptious to assert that in these cases occupational therapy contributed to the adequate care.

Community Organization. . .

(Continued from page 27)

Massachusetts General Hospital the condition of his uncle who had just been operated on for "inflammation of the bowels." It is remembered clearly because it was the only phone in town; because it was the first time that your speaker had ever used a phone, but mostly because in his ignorance, he insisted on listening at the mouthpiece and speaking into the receiver. In those days one's parents and neighbors in the community looked upon hospitals with dread and fear. Anyone that was ill enough to need hospitalization was indeed seriously ill, in their opinion, and the hospital was felt to have a very close alliance with the undertaker. Hospitals were dreaded places.

Results of Publicity

How different is the viewpoint of most people today! With the increased publicity that has been given to hospitals, with a finely improved attitude towards hospitals that has been brought about by the hospital social service workers and the medical social workers, by a marked change in the attitude of hospital personnel and with keen interest in hospitalization that has been aroused by hospital insurance plans, people as a whole no longer dread the hospital. We have heard discussions on the thought that many people now go to hospitals that should stay at home. Personally I question the soundness of that observation and believe that in the future, most people will present themselves for hospitalization even with very minor ailments.

If we are going to experience a markedly increased demand for hospital facilities and all that goes with hospitalization, we are going to be able to meet that demand only insofar as the general public is completely "sold" on our hospitals. As our hospitals are regarded, so to a large measure is our whole community organization regarded and it therefore becomes essential to the good of our whole public welfare that the attitude of the general public towards hospitals and hospitalization continues to improve so that our hospitals reach the high position of honored prestige that should be theirs. In this work, the medical social workers, the hospital social service staff, the visiting nurses and the whole hospital staff have played a large part and will continue to play an increasingly important part. My message to you is that if every individual connected with social service, with hospital service in any form, will always appreciate that in their contacts with the public they are the ambassadors not of their particular activity but of hospitals and all other community service organizations, and that as they conduct themselves so will the community service organizations be judged, and if in keeping this in mind they will always do their utmost to promote a favorable attitude towards all community service on the part of all with whom they come in contact, then indeed they will be performing a valued service and doing their part to make this world of ours a better place in which to live.

Discussion by Rev. John Bingham, associate director, Division of Health, Catholic Charities, New York, N. Y.

The topic presented is certainly one that is both timely

(Continued on page 54)

Department of Nursing Service

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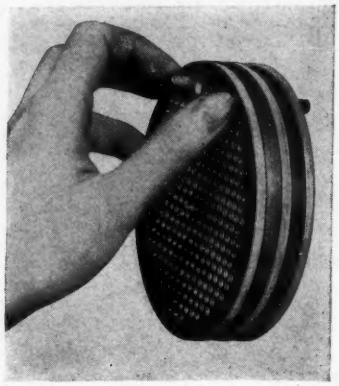

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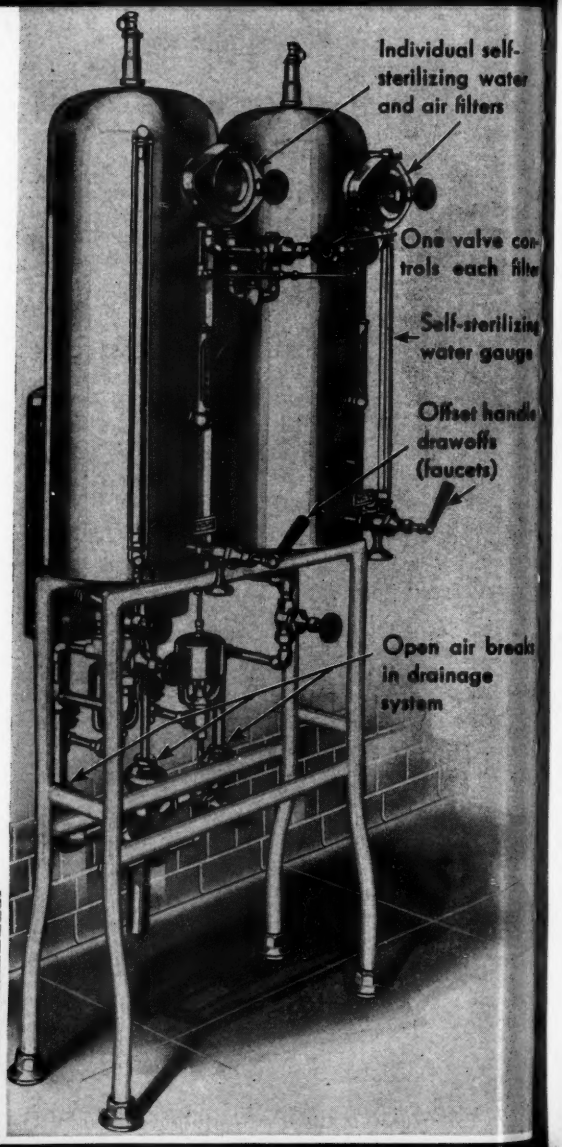
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DEPARTMENT OF NURSING SERVICE

WINNIE ANNE COX, R. N.
Associate to the Director, Cook County School of Nursing, Chicago, Ill.
EDITORIAL DIRECTOR

A SHORTER WORKING DAY FOR PRIVATE DUTY NURSES

By MRS. BERTHA F. GOODMAN, R. N.
Chairman, Private Duty Section, Illinois State Nurses Ass'n

» » » WORKING PEOPLE the country over have, through concerted effort, brought about the reality of shorter working days. Not the least of these working people are the registered nurses. All of us are aware that nurses have, for years, endeavored to endure twenty and twenty-four-hour duty. We are also aware of the devastating effect such long hours of duty have had upon the splendid nurses of the past and upon many nurses of the present.

In the past twelve or fifteen years the work-day for nurses has, in most communities, been shortened to twelve hours, and at the present time in more than 900 hospitals scattered over the United States, private duty nurses as well as institutional nurses are enjoying the manifold benefits of an eight-hour day. Some of the many advantages of the eight-hour day are: (1) More efficient nursing care for the patient; (2) increased employment for nurses; (3) satisfactory leisure time and opportunity for professional and cultural growth for private duty nurses.

Proof of satisfaction to the patient who has experienced care by special nurses enjoying the eight-hour day is indicated in the reports of directors of nursing in those hospitals in which the eight-hour plan has been established. Reports show that approximately 98 per cent of the patients approve the shorter day because, according to the statement of the patients, better nursing care is received due to the lack of fatigue on the part of the nurse.

When a new system of procedure is undertaken affecting the affairs of several different groups of people, difficulties, of course, will arise which must be diplomatically met and overcome. In many communities these obstacles have been removed through the education of the groups concerned; communities have been enlightened concerning the sound reasons for this proposed change in the working day of the private duty nurse. Perhaps nurses in communities still showing antagonism to the shorter day will appreciate suggestions which might prove of an assistance in discussions of the eight-hour day policy.

The paramount objection will probably be that of the increased cost of nursing care. Many patients will say that they cannot afford two nurses, much less three. This may be true, but the patient will certainly save little by continuing under the care of a nurse who in less than twelve hours is physically unfit to do more. At times it would be far better for a patient to take a less expensive room rather than submit himself to unsatisfactory nursing care. No one can deny that a patient in need of special nursing service requires an alert nurse. It will not be disputed that fatigue lessens efficiency; consequently, it does not seem plausible that a human being could be alert after working twenty consecutive hours.

To be sure, the nurse on 20 or 24-hour duty is supposed to sleep at night, but this at best is a frequently interrupted and unrefreshing sleep; but if a nurse does sleep can she watch a patient in the manner in which a seriously ill person rightfully deserves to be cared for? We know that complications may arise at night just as well as they may arise during the day, and that by the prompt recognition and treatment of such complications a life may frequently be saved. So often the patient is unaware that a change in his condition is taking place; sometimes even when he is aware of it he hesitates or perhaps is physically unable to arouse his sleeping nurse. With the abolition of the old system under which the nurse is supposed to sleep at night but be "on call", the patient's life would be subjected to much less danger. It should be carefully explained to hospitalized people that when a patient is out of danger it is the proper procedure to dispense with the night nurse and call the general staff nurse who is awake at all times.

We are beginning to see that the principles of health and hygiene apply to all—to nurses as well as to pa-

Presented at the annual convention of the Illinois State Nurses Association, Springfield, Illinois, October 21 to 24, 1937.

tients. The modern world does not regard caring for the sick as one continual emergency or crisis in which the health of hundreds of young women may be sacrificed. Such a necessity does not exist. We realize now that long continued fatigue impairs the efficiency of the institution as a whole, as well as of each individual in the nursing personnel. The best hospitals realize that the twenty-four, twenty-hour and even the twelve-hour duty, lowers the morale of the institution, as well as encouraging informality and familiarity. Nurses should not be expected or permitted to sleep in the rooms of patients or in close proximity to the sick; negligee is not suitable to a personnel that must be ready to respond to the call to work at any moment. Very few hospitals have dressing rooms and rest rooms for nurses, and as a result public criticism arises.

Nurses do not ask for twelve-hour or eight-hour duty with any craving for luxury, or with disregard for the patient's welfare, physical or financial; they only ask for conditions which effect improvement in the nursing care for patients and which are not entirely destructive to the health and general morale of the nurse. Few nurses can qualify for work after two or three years of continued fatigue from excessive hours of work or excessive hours of professional idleness. It is impossible for a nurse to remain physically and mentally fit when she must endure interrupted sleep, unsanitary arrangements for sleep, lack of fresh air, lack of recreation, especially outdoor recreation, and no opportunity for culture or professional growth.

It is regrettable, but true, that a small percentage of private duty nurses prefer the twenty-hour duty to the twelve or eight-hour duty because of the greater financial compensation per day. Such short-sightedness on the part of those nurses sets them apart as a minority, uncooperative and unprogressive, compared with the remainder of the nursing profession.

But how does the shorter day affect the income of the special duty nurses? Nurses who are working the shorter day in certain communities report that the actual compensation for the nurse's service per hour is increased; the daily income is less, but the yearly income compares favorably with the income of the longer day. This is true because of the increased days of employment throughout the year. The healthier and happier state in which the nurse finds herself at the end of a year after eight-hour duty, and the satisfaction she finds in the new freedom cannot be computed in figures, but does more than balance the scale.

If the nurses in any given community wish to inaugurate the shorter day, they must proceed wisely and slowly. No drastic change can take place over night and be permanent and satisfactory. The ideal can only become a practical reality when a majority of these groups involved in the change, the nurse, the patient, the hospitals and the physicians, cooperate in the inauguration of the plan.

In various communities where the shorter day has been adopted, it has often been the result of a quiet and long continued effort on the part of the alumnae association of the local hospital. The alumnae association has presented the plant to the hospital executives, both to the director of the nursing service and to the hospital superintendent. The alumnae association has set forth the benefits of the twelve-hour or eight-hour day and requested its adoption. In many instances this request has been referred to the medical staff and the board of trustees by the superintendent of the hospital concerned. In other cases, the alumnae association has presented the plan to the medical staff and the board of trustees directly without the intermediate action of the hospital executives.

In some localities the district nurses' association has voted to adopt a shorter work day and obviated any necessity for lengthy debate with other parties. This is only possible when practically one hundred per cent of the members of the district association is in favor of the adoption of the eight-hour day. Merely voting for the shorter day at a local meeting of the nurses' association does not insure the inauguration of the policy.

On the whole it is better that the proposed plan be thoroughly examined and understood by hospital executives, board of trustees and medical staff before it is actually put into operation. One successful plan for bringing about this mutual understanding is through a conference sponsored by officers of the given district nurses' association to which hospital executives and members of the local medical society may be invited. A reasonable degree of understanding has been the result in many instances where cooperation has been sought in this way. Any plan for the inauguration of the eight-hour day, in order to stand a fair chance of adoption, must have these characteristics: (1) Close cooperation between the administration of the nursing service and the special duty nurses; (2) Enthusiasm on the part of the administration of the nursing service, and ability on the part of the superintendent of nurses to interpret the needs of the special duty nurses to trustees and medical staff; (3) Above all, the overwhelming majority of the special duty nurses in the community must be heartily in favor of the shorter day.

On this subject all nurses should read the following articles from the *American Journal of Nursing*:

"Twelve Hour Duty"—Ruth Brown, Vol. XXIV, p. 435. March, 1924.

"Twelve Hour Duty"—Merle Duncan, Vol. XXIV, p. 441. March 1924.

"Twenty-Four Hour Duty from the Standpoint of the Nurse"—Esther O'Dowd. Vol. XXIV, p. 442 March 1924.

"The Eight-Hour Day Makes Progress"—Ethel Swope. Vol. XXXIII, p. 1153. December 1933.

Mrs. Korngold Resigns Editorial Position

» » We regret to have to announce that Mrs. Janet Fenimore Korngold, who has so ably edited the Department of Nursing Service of HOSPITAL MANAGEMENT, has found it necessary to resign because of the pressure of other work. Mrs. Korngold opened the department in the January, 1937, issue, and throughout the year has devoted a great deal of time and thought to the problems of hospital nursing.

We have, however, been extremely fortunate in that Miss Wnnie Anne Cox has consented to conduct the Department. Miss Cox is an associate to the director of nursing at Cook County Hospital, and is widely known in the field of hospital nursing. She will continue to make the department one of the means of contact between the nursing service and the administration.

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THE CENTRAL SERVICE DEPARTMENT

By SISTER MARY IGNATIUS
Mercy Hospital, Denver, Colo.

Nurses preparing trays for sterilization in Mercy Hospital's Central Service Department.

» » » WHEN THE FIRST central service was originated, its main purpose was to facilitate nursing service, to minimize the preparation of equipment, and to make hospital care of the patient of the most efficient type. Then, too, with the realization of the expense caused by waste, improper care, and inadequate preparation of hospital equipment for treatment and the care of its patients, an organized central service became an ideal. With this department a reality came the satisfaction that the best care for patients was provided by proper equipment and sterilization.

A well-ventilated and lighted room, conveniently central to all departments, with ample press and storeroom space; the necessary sterilizing apparatus and adequate provision for the cleaning and preparation of equipment pictures the ideal plan of a central service. The personnel of this department should consist of a graduate nurse as the supervisor, with efficient graduate nurses, student nurses and maid service to assist in the prompt reassembling and sterilizing of returned articles.

When first organizing a central service there should be sufficient equipment to serve all departments before their immediate supplies are removed. To insure efficiency in the care of articles taken from central service, requisition slips are a necessity. On this slip is written the name of the patient, the room number, article obtained and the signature of the nurse procuring the article. To minimize time in checking return of articles to central service, a numerical file for each department is maintained. The nurse who signs the requisition slip is directly responsible for the return of that article in good condition and at the time specified by central service rules.

The intelligent senior nurse anticipates the needs of the doctors whom she is to assist, and procures the necessary trays from central service before the doctor's visit. Service carts, large enough to convey requisitions for an entire department, are furnished.

Every type of tray used in the treatment of the patient should be included in the central service and the individual requirements of the doctor must be supplied with his service. A minimum, yet adequate, rather than a surplus of equipment should be in circulation for general use.

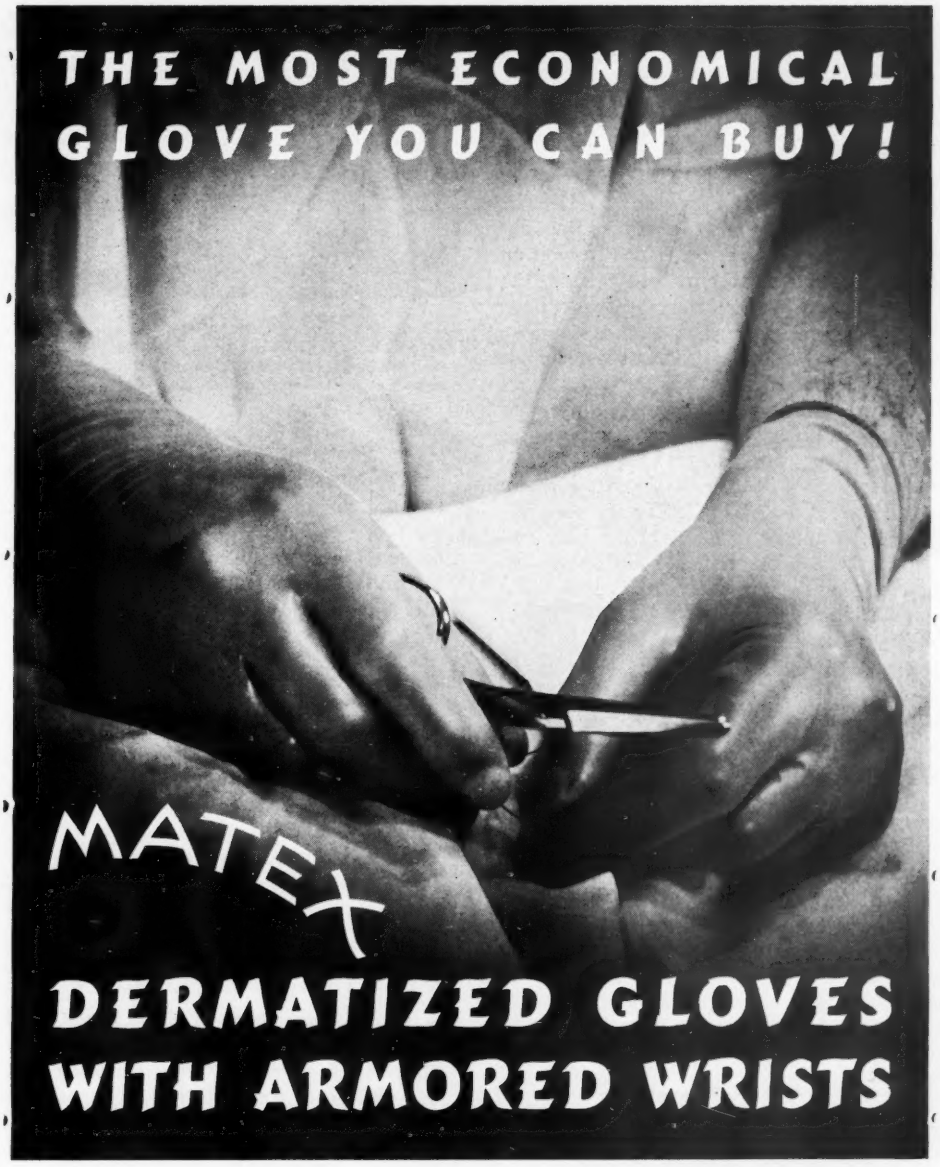
In order to recognize needed replacements, continual and careful inspection of equipment must be made to keep it in excellent condition. This checking prevents loss, demands replacements from breakage, and insures longer life of articles; therefore, the initial cost in the organization of central service is only a temporary expense.

Central service should be included in the student nurse's curriculum for a definite period. Here, she is instructed in the correct method of assembling trays for treatments, the value of aseptic technique, the making and sterilizing of dressings, packs, and drains; the method of making and sterilizing saline solutions for intravenous and hypodermoclysis injections, and solutions for irrigations—all of which are done under constant supervision. During her time in this service, her work is checked by the graduate in charge.

The ideal is the twenty-four hour service, although efficiency may be attained with the sixteen-hour, by extending time accommodation to the nurse reporting for duty at eleven p.m. Emergency necessities from 11:30 p.m. 7:00 a.m. may be obtained from the night supervisor of the hospital. An emergency cart, supplied with first-aids for the treatment of wounds, infections, poisons, burns, and sprains; emergency narcotics and stimulants should be in constant readiness.

The department should aim to be a valuable service to the patient, to the doctor, and to the nurse; thereby becoming a most valuable asset to the hospital in spelling the words: sufficient efficient service.

Checking out the service carts and requisitions for the departments in the Central Service Department at Mercy Hospital, Denver.



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A Simple Method of Using Antiseptic Baby Oil

By D. BODINE STORMS
The Mennen Company, Newark, N. J.

» » In a previous article which appeared in the Department of Nursing Service, it was shown that there is more than one right way of carrying out the procedure of oiling the newborn babies in nurseries. Following is a workable technic that offers simplicity with a minimum of equipment.

The use of cotton pledgets has been eliminated in many nurseries; there has been the thought that they have been irritating to the newborn's skin, and they are wasteful. The pledget absorbs much of the oil and when it is thrown away there is possibly as much oil in the pledget as there is on the baby's body. Applying the antiseptic oil directly to the baby's body, rubbing in with a gentle massage, has seemed to produce better results. The oil is brought in more intimate contact with the skin and gets down into the folds and creases much more effectively. This method also insures a more even distribution of the oil on the baby's body, doing away with the appearance of greasiness.

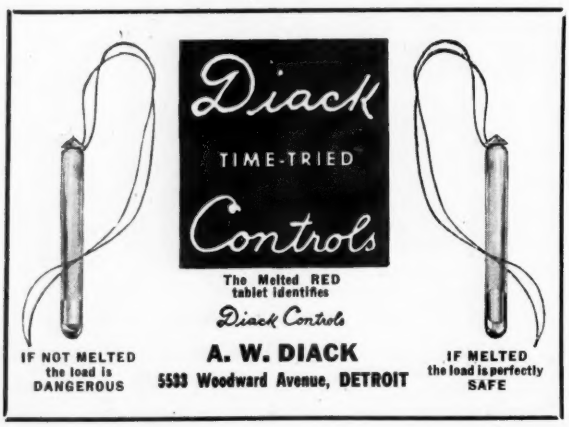
It has been found that one half ounce of antiseptic oil is ample to cover the entire baby's body. A quantity of half ounce bottles, which are supplied by the manufacturer, is filled each morning to take care of the daily census. These bottles have a small shaker top opening so that when the bottle is tipped to apply the oil it does not gush out but takes about eight seconds to shake out of the bottle, giving the nurse an opportunity to distribute the oil evenly over the body, and to massage it in a gentle manner into the skin. The empty bottle is then placed in the tray with the other empty bottles.

A fresh half ounce bottle of oil is used for the next baby placed on the bath table. This offers a splendid individual technic and eliminates going from a baby to a common container and then from the container back to another baby, thereby offering a prevention against cross infection.

The cleansing of the half ounce bottles and screw caps is accomplished by placing them in the autoclave, ten minutes on steam, then ten minutes on vacuum, the latter assuring that the inside of the bottle is dry. Although the openings in these bottles are small it has proved to be a simple matter to fill them by using an ounce syringe.

There are two prominent advantages to be considered as being offered by this procedure: a perfected individual technic and the attainment of a decided economy. The use of the half ounce bottle controls the amount of antiseptic oil used, and the cost of the cotton pledgets is eliminated. The simplicity of this technic has cut nursing time to a minimum.

The small bottles illustrated are used in the individual technic recommended. Each bottle contains just enough oil for one baby and when the screw cap is removed, a small opening is revealed, allowing slow emptying of the bottle with even application of the oil.



Nurses Propose Shorter Hours

» » In Louisiana the subject of shorter nursing hours is under discussion and the effective operation of the eight-hour working shift will form one of the principal objectives of the administration of Miss Edith Faris of Monroe, who was elected to the presidency of the Louisiana State Nurses' Association at the annual convention of that organzation.

Registered Nurses Organize

» » Registered nurses of Barry County, Michigan, have met and organized a Barry County Nurses Association. Officers are: President, Mrs. Bessie Brown of Nashville; vice president, Mrs. Edward Lowry of Delton; secretary-treasurer, Mrs. Verne DeMott of Hastings.

Eight-Hour Nursing

» » An eight-hour schedule for graduate nurse service beginning Dec. 1 has been agreed upon at a combined meeting of graduate nurses and the medical staff of St. Francis hospital, Evanston, Ill., it has been announced. This will effect a change in the hours and fees of graduate nurses but will necessitate no additional cost to patients. Fees for three nurses working eight-hour shifts in each twenty-four period (plus cost of meals), amount exactly to the same total as fees for 12-hour shifts where two nurses alternated for the 24-hour period.

MEDICAL RECORDS DEPARTMENT

EDNA K. HUFFMAN

Director, Training School for Medical Record Librarians, Grant Hospital, Chicago

EDITOR

THE MEDICAL RECORD AS THE KEYNOTE OF UNITY OF THE HOSPITAL STAFF

By AVIS DARROW

Medical Records Librarian, Samaritan Hospital, Troy, N. Y.

» » » AT FIRST THOUGHT, this subject seems to be demanding of the record something that does not lie within its province. The best way to test whether or not this is so seems to be to follow the patient throughout his hospital adventures and see for ourselves just what members of the staff come in touch with the record.

The patient meets the admitting clerk and is gently but firmly separated from all relevant vital statistics and social data. This is the foundation upon which the rest of the record is built. The better the admitting clerk does her work, the easier it is for all the others who follow.

The patient meets the nurses, and is escorted with proper ceremony to his chosen accommodation. From that moment until his departure, the nurses, from supervisor to probationer, are forever occupied in recording in one notebook or another facts that are copied in the chart. To an outsider, this feverish preoccupation with charting would be bewildering, but nurses have been trained to realize how very essential it is. Memory may fail but an accurate observation truthfully charted will always remain. The nurse's responsibility is large as she copies doctor's orders on the treatment sheet, writes the bedside notes, charts temperatures, pulse and respiration, and also keeps records on any special sheets required, such as blood pressure, intake and output, etc.

The next person to enter the life of the patient is the intern. It is his duty, as the representative of the hospital and the attending physician, to obtain a complete history of the case, past and present, to make a thorough physical examination and to record all his findings. The progress of the patient must be carefully followed by him and frequent notes made to complete the picture of the patient's reaction to treatment. The attending physician must not forget that he is responsible for checking the intern's work and amplifying it or correcting it when necessary.

The patient may never meet any member of the laboratory staff, and may hardly know that it exists as witnessed by the fact that so many ask, "What is that fee for?" when they receive their bills. However, numerous laboratory reports testify that the technicians, and in surgical cases the pathologist, have work to do for every patient.

Not every patient visits the X-ray department, but to the patient who does it means meeting the roentgenologist and the X-ray technician, and posing for a very unflattering picture. In some cases X-ray treatments are given. In either case, the X-ray staff must contribute a written report to the chart and file all films for future reference.

The basal metabolism and the electrocardiograph departments may make other diagnostic tests that bring into the care of the patient, and into the make-up of the record technicians and physicians from those departments.

For some time the patient has been looking forward to visiting the operating room with a morbid satisfaction, and a staff worthy of the great occasion is ready to greet him when he makes his appearance—the surgeon, the assistant surgeon, his old friend the intern, the anesthetist, and the nurses. To this staff, the operation means that a report of the findings and the surgical procedure, complete with preoperative and postoperative diagnosis must be prepared for the chart, and it usually takes the combined efforts of all the operating room staff to induce the surgeon to dictate his share promptly.

When the patient requires a special diet, not only during his stay in the hospital, but following his discharge, it may be necessary for him to visit the dietitian. Here the patient becomes a student, and as a diploma receives a schedule of menus which serves as a constant reminder to stay on the straight and narrow path of dietary discretion.

In this discussion, we may ignore any department which does not contribute directly or indirectly to the record, although the patient may find it impossible to do so, espe-

Read before the Adirondack Record Librarian's Association.

cially the book-keeping department which he usually contacts on his departure.

It is now time to say good-bye to the patient, to close the chart, and send it from the ward to the office of the medical records librarian.

The patient may return to the out-patient department for follow-up treatment. In many instances he was originally treated in this department and then referred to the hospital. A complete staff including social service worker, nurses and clinic physicians here care for the patient and keep records following the same principles of accuracy and thoroughness that is observed when the patient is hospitalized.

Eventually the medical record is all that remains of the patient's visit to the hospital and his side excursions into all the various departments. Its use as a personal document will only be renewed when insurance papers have to be filled out, legal questions settled, or some future illness arises. Its life and usefulness as an impersonal document, however, is only beginning and now we can consider what each contributor to the record is able to receive from it, as a reward for earlier work.

The medical records librarian first examines it to see that all reports are present and pries all manner of statistics from it for her files. In case any report is missing, it is her duty to hunt it up and in this capacity she soon becomes familiar with every department of the hospital, as omnipresent as an insurance salesman.

The attending physician makes his final check of the chart and signs it. He may later prepare a case study for presentation at a medical meeting, or use it as one of his fifty cases when applying for fellowship in the American College of Surgeons or Physicians. If so, he soon regrets any carelessness or omissions on his part in checking the record while the patient was still in the hospital.

The instructress of the School for Nurses borrows the record to demonstrate to the student nurses a typical case of a particular disease, or a new treatment, or as a good or horrible example of charting.

The intern committee may use the record to ascertain whether the intern is carrying out his responsibilities or possibly whether he is getting sufficient experience during his internship.

The medical record committee of the staff, if there is one, acts as a final check on the accuracy of the chart, supervising the work of the attending physician and the medical records librarian.

To the hospital administrator the record is perhaps most useful of all. From his viewpoint a good record is one which adequately protects the patient, the doctor and the hospital. From the record, the work of the medical staff, as a whole and as individuals, may be evaluated. The work of the contributing hospital departments may be judged by the reports rendered and, finally, it offers a means of comparison with similar hospitals.

A common interest in the record, although for individual reasons, leads to interests in each other's problems and to an exchange of helpful suggestions; at least, I have found this true of the record department. The fact that each hospital department seems an entity in itself, following its own sometimes monotonous routine and striving with its own peculiar problems, makes each too prone to self-pity. We feel very alone and unappreciated, not unlike a "neglected wife" or "misunderstood husband". We need to remember what the administrator has always known and what the medical record so vividly proves. Each department has its own importance in the hospital world and only by working in unison, each cooperating freely with the other, does the whole program achieve success.

Keeping Up-To-Date Educationally

By LEONA J. BOHACH, B.A., M.A., R.R.L.
Iowa Methodist Hospital, Des Moines, Iowa

» » While reading a book the other evening I came across the term, "human robot". This the author described in brief as a trained person who followed a certain routine day after day, making no progress and doing no real thinking. This sounded distasteful to me at first but I could not help but feel that many of us in record work are gradually becoming that type of creature. We work hard all day doing our routine work and when the day is done we close our minds just as we close the door to our office.

When leaving school we are filled with enthusiasm and dreams of the future. We buy books, attend conventions, and we make long lists of changes needed the moment we start our first job, but as time goes on the enthusiasm ebbs away and we quiet down, becoming a human robot. Perhaps this is due in part to the positions we hold. Maybe we are in small hospitals where there are many duties to be performed beside the record work, and we are so rushed each day we have little time to put our ideas into action; or, we work in such large hospitals that we are responsible for but one phase of the work which is so closely supervised that we forget there might be other ways of doing it. Then, too, we may be in an institution where the staff and administration are unwilling to make changes and we finally decide, "What's the use" and take the line of least resistance, the rut.

However, we must not allow our enthusiasm to die out. We must keep up our scholarship and continue mental expansion. Many say, "I am too tired at the end of the day, I do not feel like studying or going to lectures". I can readily understand that for I too know something of that weariness, but that only means that one must put forth a little more effort.

There is plenty of material available. If you wish to own and study some general standard work there are the books by Minnie G. Morse, *The Medical Secretary* published by The MacMillan Co. which gives the fundamental points in record work. This is simply written and has proved most helpful to those just beginning work in the medical field. Her other book, *Hospital Case Records and the Record Librarian* (Physicians' Record Co.) gives more detailed information as to what the case history should include, various methods of indexing as well as other reference material. Dr. T. R. Ponton's book, *Nomenclature of Diseases and Operations and Manual of the Medical Record* (2nd ed.), published by the Physicians' Record Company, should be in every record office and owned by every student of medical record work. This manual gives a clear picture of every step in case study work and is excellent for references. In 1935, Dr. Malcolm T. MacEachern's book, *Hospital Organization and Man-*

agement, was published. This volume serves more to broaden the general knowledge of the medical record librarian in the hospital field, but she would be particularly interested in Chapter XIII, "Medical Records Department". This chapter takes up in detail the various phases of the work carried on in the department. He begins with the value of the medical records, its uses, the various systems used in hospitals, and closes with a complete resume of the monthly analysis and annual report. This work is recommended for study for those who are thinking of taking the examination for registration.*

Bulletin and magazine articles are always available. HOSPITAL MANAGEMENT now has a section for record librarians, "Modern Hospital" often has thought provoking articles on record work. Our own Bulletin put out by the Association of Record Librarians of North America publishes a bibliography which gives the names of articles in other magazines. One should read this publication carefully for it is here that the inspiration for the medical record librarian may be found. The January 1937 issue of the Bulletin of the American College of Surgeons has an excellent bibliography to which one may refer for material on anatomy, history of medicine, etc. But you say that you work in a hospital that has no medical library or you are in a locality where lecture courses are not available, and you do not earn enough to buy the magazines. That is an excuse but not a good reason for being lazy. The American Hospital Association sponsors a package library which sends the article, book or pamphlet to you for the cost of postage. Many colleges and universities offer this same service and in New York State as well as other states there are excellent state medical libraries which are ready and willing to assist you in collecting material on almost any subject you wish to study.

Reading medical magazines proves worthwhile in other directions. Have you ever read some articles on let us say diabetic coma or ulcerative colitis and then casually suggested some of the points to a doctor who is puzzling over a case or is doing some research on the subject? If you do it right, he will be delighted to find someone interested in the same work he is, and it may lead to further discussion, to helping prepare a paper and best of all, to the completion of his histories. One record librarian did this and some time later overheard the doctor tell a fellow worker, "She really does know something after all".

Are you acquainted with the booklets put out by firms that make hospital supplies? I learned all I know about sutures and surgical instruments in this way. The diagrams and pictures they issue from time to time are often helpful at local association meetings. Some of the nursing and dietetic journals often contain articles that may serve the record department. Not many months ago there appeared in one of these magazines an article on practical psychology. True it was meant for dietitians, but it had many points of value to the record librarian.

Have you been reading any of the medical magazines that deal with general hospital problems? You answer, "No, I never thought they had any bearing on my department." Maybe not, directly, but by reading articles on hospital administration you realize that the super-

*Since receiving this article from the author, Dr. MacEachern's new book "Medical Records in the Hospital" has been published, and was reviewed in the December issue of Hospital Management.

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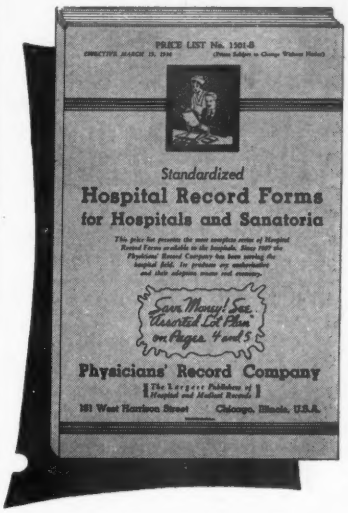
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intendent has other things to think about beside the record department. You understand for instance why the housekeeper is so impatient when you learn of the trying situations with which she has to cope. If you know a few of these things you naturally become more tolerant when it comes to getting answers to your own problems.

If you belong to a local association, you might insist that you branch out more in your meetings and along with the study of anatomy and physiology take up current events in the medical field, new medical terms, etc. Attend the state meetings and try to go to the national convention. You may not be able to put the new ideas into practice at once but you have something in the back of your mind about which to think.

One might go on indefinitely for in no department in the hospital is there opportunity for such a wide range of knowledge, and the well informed record librarian not only wins out in time, but also has the quiet satisfaction that she is not a "human robot" at heart.

Community Organization . . .

(Continued from page 42)

and important. I do not feel that Mr. Orchard was guilty of any exaggeration when he stated that "The hospital is the most important agency in community organization." From the community viewpoint, the voluntary hospital cannot be maintained or operated as a segregated enterprise. In our modern community the hospital has a definite and necessary place. Health is a matter of general welfare and the hospital, since it promotes better health, functions for the common good. This point was emphasized in a rather convincing fashion in a brochure brought out by the United Hospital Fund in New York during their 1936 Campagn:

> "Eighty per cent of the city's population go about their daily life economically self-reliant. The other twenty per cent, to some degree, are dependents.
>
> No matter how independent
>
> Yet all New Yorkers, including every one of the self-reliant, from the office boy to the top men of business, depend upon the community for certain protection.
>
> The police protect life and property.
> The fire department answers the cry "Fire!"
> When sickness, accident and disease strike,
> we all turn to another community service,
> our hospitals and our doctors.
>
> And this year the hospitals ask you to think of this service not merely as a necessary philanthropy for the care of the sick poor, but as a vital community service for your own protection".

The past decade has seen a great development in agencies of general welfare. There are numerous groups working in a variety of areas for the purpose of meeting human needs, social, economic and spiritual. Most of these agencies have need for the cooperation of those in the health and hospital fields in order that they may plan and provide adequately for the people they are endeavoring to assist. The hospitals then have an obligation to cooperate in order that the task of helping those in trouble may be carried on efficiently and effectively.

There is no question as to the fact that the hospital should play a role in community organization, but what is the medium through which the hospital may most effectively participate? I feel that since the community aspect of the hospital's service is largely extra mural the social service department should be the locus for the major development of the community relationship.

Discussion by Fred W. Heffinger, superintendent, Mercer Hospital, Trenton, N. J.

Dr. MacLean, in his discussion of the hospital's place in community organization, has escorted us up and down the hospital's corridors, stopping in each department to demonstrate its particular potential usefulness in making and keeping the community health. He depicts the hospital as the hub of the wheel of public health, each department an important spoke with a definite load to carry; and he suggests practical ways and means to develop these radial contacts for the maximum good of the greatest number.

Mr. Orchard, with the authority of long experience, gives us in a few words the confirmation, if we need it, that the public has accepted the hospital as an essential and welcome health service of community-wide reach. In doing this, he makes a very important contribution, for the final test of the practical value of a service is whether the public is willing to buy it. From him we have the assurance that there is no better appeal than health-help in any philanthropic crusade, and that the recognition of the hospital as the center of the community health program is limited only by our own success in carrying the story as well as the performance to the public.

The advantages of a unit medical records system which can give us in orderly assembly all pertinent information from first to present contact has been well established. For better or worse, the trend of health services inclines to increased specialization both in and out of hospital practice. If we admit that the patient himself deserves at least as much consideration as his medical record, we accept the necessity of the personal sponsorship and the continuous interest in his combined medical, social and economic problem, which is the particular function of the medical social worker. It is the medical social worker who is the patient's ambassador in the courts of health and as such, in the routine pursuit of efforts in his interest, establishes friendly relations in all the many avenues that radiate from and to the hospital as the center of community health.

To you who are actively engaged in medical social work, I offer the suggestion that when you return to your labors you take with you a renewed consciousness of the important role that you play in the promotion of this coordination. There is no added responsibility involved, no extra effort required. The fostering of community-wide participation and leadership of the hospital in health activities is enormously advanced by the routine multitudinous contacts that you make every day. It is a natural off-shoot of your business of helping the physician to obtain the best possible results and the most lasting benefits from his art, by the economic and social cushions you provide for the recipient who is being "taken for a ride" by illness. The automatic by-product of your daily activities is this very promotion of the extension of the hospital into the community which is the subject of this entire discussion. When you are called upon to demonstrate the dividends from the investment in your department, do not fail to mention this hidden asset.

ANESTHESIA, PATHOLOGY, X-RAY

BEN MORGAN, M.D.
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CONTRIBUTING EDITORS

FINANCING LABORATORY SERVICE

By BENJAMIN T. TERRY, M. D.
Director of Laboratories, Tacoma General Hospital, Tacoma, Wash.

» » » FINANCING laboratory service is a difficult problem. It has been discussed for many years and as yet no satisfactory solution has been found which will apply to all hospitals. Conditions differ in hospitals, and when one attempts to adopt a method used successfully by another it is nearly always necessary to modify that method, either immediately or in the course of time.

To finance laboratory service, the hospital must provide funds to pay the pathologist and the technicians, to equip the laboratory, to furnish it with supplies, light, heat, and janitor service, to provide for insurance and to take care of depreciations. To provide the funds for the laboratory service, the money, in case the hospital is not endowed, must be obtained either from the patients in the hospital or from patients outside the hospital as a result of work done for them. Many plans to raise the necessary money have been tried.

In general one of three systems is followed: The first is to establish a schedule of charges for laboratory work and to charge the patient for each service rendered. This has been called the "a la carte" or fee schedule system. Patients as a rule do not like it. This system makes it difficult for people to estimate in advance how much the hospital bill will be, and because of the friction this method has caused, it is not used alone in the majority of hospitals.

The second is the flat rate method. Instead of charging the patient for each test made in the laboratory, a flat sum is added to the bill of each patient for laboratory service. This method has many advantages. From the hospital point of view it makes the bookkeeping very easy. It is also a great advantage to patients who have a great deal of laboratory work done for them. The main objection to it is that patients who have very little laboratory work may complain that they are required to pay, in part at least, for laboratory work done on other people.

The flat rate employed varies in different hospitals. Sometimes it is three dollars or less, sometimes four dollars, sometimes five dollars or more. Many modifications of the flat rate have been made in the attempt to make the method less burdensome on patients who have little laboratory work done. One suggestion, called the "Jolly System," was to have a graduated flat rate. Every time the patient, according to the scheduled rate, consumes $15.00 worth of laboratory work, he is billed, not for $15.00, but for $5.00. By this system the flat rate goes up from $5.00 to $10.00 to $15.00 or even to $20.00 or more. This system can become quite a burden to some patients.

The second flat rate method has a minimum, an intermediate and a maximum rate. Every patient that comes into the hospital and stays over twenty-four hours, is charged a flat rate of $2.50. This rate pays for urine analysis, blood work, and might include a Wassermann and Kline.

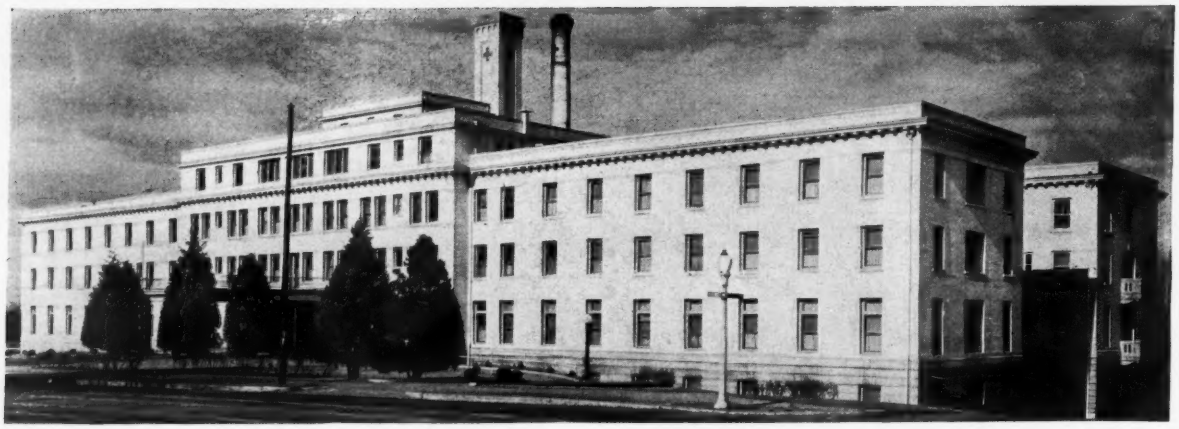
The intermediate flat rate adds $2.50 to the minimum rate, making $5.00 This $5.00 flat rate becomes effective when a patient who has had the minimum rate goes to surgery and a tissue examination is made. This means that the tissue examination costs $2.50.

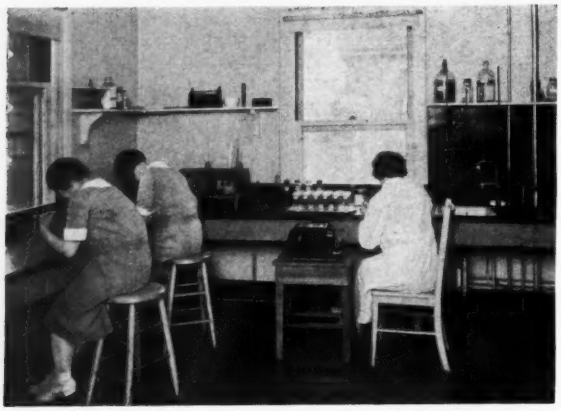
The maximum flat rate is $7.50. The maximum flat rate is charged when a patient paying the intermediate rate has some of the more difficult chemical tests done. This maximum rate permits the repetition of one basal metabolism test. Some hospitals stop at this. Others have a rate of $10.00 when it becomes necessary for expensive tests to be repeated three, four or more times. If four rates instead of three are to be charged, we might call this one the "One, Two, Three, Four Flat Rate System." This graduated flat rate seems to work out well.

In some hospitals the flat rate is concealed by adding a small sum to the daily room rate. This sum may be fifty cents. For patients who stay only a short time in the hospital and who have a fair amount of laboratory work, this method has its advantages.

The third method is a combination of the "a la carte" system, a variable flat rate system, and an extra charge

Presented at the Sectional Meeting of the American College of Surgeons, Seattle, Wash., April 1 and 2, 1937.





An exterior view of the Tacoma General Hospital, Tacoma, Washington. Directly above, a corner of the laboratory in Tacoma General hospital.

system. This is the method used at the Tacoma General Hospital in Tacoma, Washington, and has for years been used with considerable satisfaction. It will be given in more or less detail.

First, a schedule of charges for laboratory work was worked out. This schedule is divided into two parts. The upper part includes all of the tests which are covered by the flat rate fee. The lower part covers all tests not included in this rate. When a patient enters the hospital, the "a la carte" system is in effect for the first seventy-two hours. Under this system, the patient pays only for the tests ordered by the doctor. If the stay of the patient exceeds seventy-two hours, instead of the "a la carte" system, the flat rate of $5.00 goes into effect. This $5.00 pays for all laboratory work done during the first week and covers an unlimited number of repetitions of tests, such as blood counts, urinalyses, bacterial cultures, smears, gastric content examinations, feces, pneumococcus typing, blood cultures, tissue examinations, etc. It does not cover the blood chemistries, the tests for poisons, basal metabolism tests, animal inoculations, etc.

After the first week the flat rate drops to $1.00 per week. This method has offered no difficulty in the bookkeeping and has been a great boon to patients who are in the hospital for a long time and who have many of the ordinary laboratory tests.

The laboratories of the Tacoma General Hospital have up to the present accommodated the doctors by going out of the hospital when necessary to obtain test material from out-patients. For this work no additional charge has been made. In many other hospitals this service costs double the original fee.

An outline of this method of charging, showing the prices now put upon each laboratory test at the Tacoma General Hospital, accompanies this article.

Before concluding this discussion, a few words should be said about securing the services of a pathologist. For a pathologist to qualify for the position of director of laboratories, he must be a graduate of an approved medical school and must have had a minimum of three years training in clinical pathology under competent supervision. He must also devote the larger portion of his time to laboratory work.

There are many ways that hospitals have of paying the pathologist. Some give a salary. Others give a salary and a percentage of the net income from clinical laboratory work. Some hospitals take the pathologist into partnership and split the net income—60 per cent to the pathologist and 40 per cent to the hospital.

The Tacoma General Hospital gives a salary which has been increased several times in the last three years. The fees for outside work done by the pathologist are his own if they result from medico legal opinions which do not require technical assistance or hospital supplies. On the other hand, the net income of the pathologist from the outside where the hospital contributes equipment, supplies and technical assistance, is divided equally between the hospital and the pathologist.

References for Further Study

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FEE SCHEDULE

Tacoma General Hospital, Tacoma, Wash.

1. Patients leaving the hospital in less than 72 hours are billed a la carte for all work ordered by the doctor in charge.

2. Division A: After 72 hours, for tests included in the upper division of this sheet, the a la carte charges are cancelled and the patient goes on a flat rate system. Five dollars pays for all laboratory work done in Division A for patients leaving in ten days. For patients staying longer than ten days, the flat rates are $5.00 for the first week and $1.00 per week for each subsequent week.

3. Division B: Is always a la carte, regardless of length of stay in hospital.

DIVISION A: CHARGES INCLUDED IN FLAT RATE OF $5.00 ($1.00 PER WEEK AFTER THE FIRST)

$1.00 Charges
Bleeding time
Coagulation time (Lee)
Blood typing (Patient)
Platelet count
Occult blood, feces
Parasites and ova, feces
Bacterial culture
Bacterial smear or gram stain
Sputum for tuberculosis
Undulant fever (B. Abortus)
Mantoux (Skin Test) for tuberculosis
Cell count, spinal fluid
Smear or stain, spinal fluid
Globulin, spinal fluid
Microscopic or chemical, urine
Routine, chem, & micro, urine
Quantitative albumin, urine

$1.50 Charges
R.B.C. and hemoglobin
W.B.C. and differential counts
Sedimentation time
Phenolsulphonephthalein, urine
Quantitative sugar, urine

$2.00 Charges
Fragility test, blood
Widal blood
Bacterial culture and smear
Culture and smear, spinal fluid
Smear and culture, urine

$2.50 Charges
Complete count, blood
Wassermann and Kline, blood
Wassermann, spinal fluid
Quantitative urea, urine

$3.00 Charges
Triple agglutination, blood

$3.50 Charges
Routine exam & culture, feces
Complete exam, gastric contents

$4.00 Charges
Pneumococcus typing

$5.00 Charges
Culture, blood
Complete gastric examination
Tissue examination

$8.00 Charges
Complete examination, spinal fluid

DIVISION B: CHARGES NOT INCLUDED IN FLAT RATES. ALWAYS ON A LA CARTE SYSTEM.

$1.00 Charges
Blood Sugar, each of a series, after the first
Each donor, blood typing

$2.00 Charges
Test for arsenic

$2.50 Charges
Chloride, blood
Creatinine, blood
Blood sugar
Phosphorus, blood
CO_2 Combining power, blood
Serum bilirubin, blood
Uric acid, quantitative, blood
Urea, quantitative
Bargen's organism examination
Colloidal gold or benzoin, Sp. Fld.
Urine, complete bacteriological and microscopic examination

$3.00 Charges
Blood typing, cross agglutination and Kline
Basal metabolism (after 1st)

$5.00 Charges
Calcium, blood
Urea clearance, blood
Basal metabolism (1st)
(For others see $3.00 charges)
Animal inoculations
Vaccine preparations
Liver function test (plus dye)
Ascheim Zondek (Friedman)
Tissue from other than Tacoma General Hospital patients, for gross and microscopic examination

$7.50 Charges
Glucose tolerance, blood

Developments in Medical X-Ray for 1937

As seen by the General Electric Company

» » Oil-immersed and self-contained, a new shock-proof type of x-ray therapy equipment rated 400 kv peak and 5 ma continuous operation was produced, which occupies only a fraction of the space required for air-insulated apparatus of like rating. The tube-head, a 4,000-lb. sealed and grounded tank containing all high-voltage parts, is vertically adjusted over the patient by means of a motor-operated raising and lowering mechanism in the left supporting column. Angular positioning through 180 deg. of its long axis is by worm and gear actuated by a hand-operated crank on the other supporting column. Positioning of the patient and directing of the radiation to the treatment area are simplified by these facilities. An oil pump within the housing of the supporting structure maintains a constant flow of oil through the tube anode, removing the heat.

Making it economically possible for practically every community to have x-ray therapy conveniently available is a new apparatus designed for 220 kv peak, 15 ma continuous operation, and having a gamma-unit output at least equal to many older types of apparatus operating at 25 ma. It has all high-voltage parts similarly oil-immersed in a sealed and grounded tank, and raising and lowering is by means of a manually operated hand crank on the supporting column. With rotation of the tube about two axes, the radiaton thus may be directed quickly and accurately to the treatment area. The Coolidge-tube anode is cooled by oil constantly circulated from a remotely installed pumping system.

To aid the surgeon in the quick and efficient localization and removal of foreign bodies from the food and air passages, a biplanar fluoroscope was developed. The apparatus consists essentially of two x-ray tubes, energized from the the same high-voltage transformer; one tube is for horizontal radiation, the other for vertical radiation. The fluoroscopic screen is so mounted that it may be quickly pivoted from one plane to the other. Variation in the opening of the lead diaphragm for each tube is obtained by motor drive, controlled through individual switches on the control panel. Two self-starting Telechron clocks are used to indicate the time either tube is energized, so the operator may know at a glance whether he is approaching the limit of skin tolerance to the x-rays. All parts of the high-voltage circuit are enclosed to render operation electrically safe to both patient and operator. The control unit also is enclosed and is grounded. If the door to the high-voltage transformer room is opened, the primary circuit is caused to open automatically. This development has been very much stimulated by the keen interest of Dr. W. Edward Chamberlain, Director of Roentgenology at Temple University, Philadelphia, a collaborator of Dr. Chevalier Jackson long noted for his contributions to this important field in surgery.

To make available to radiologists an x-ray energizing unit with sufficient power to obtain every possible advantage in their use of the rotating-anode Coolidge tube announced last year, a new high-power transformer with greatly improved control was introduced. The 52-button autotransformer control offers refinement unprecedented in radiographic equipment. With the unit rated 85 kv peak and 500 ma, each button of the autotransformer control represents a change of 1.8 kv peak; and the voltage

value of each step is constant throughout the entire milliamperage range of 10 to 500 ma. Duplication of results can be obtained much more consistently with this equipment. The oil-immersed kenotrons for rectifying the current, of a new type developed specifically for the purpose, are in the transformer tank.

High Voltage X-Rays

» » Announced recently by General Electric Co.'s research laboratory was a developmental oil-immersed x-ray outfit for 500,000-volt operation and an oil-immersed multi-section x-ray tube. The outfit is of the shock-proof type, is semi-portable, and does not require a special building to house it. The x-ray target operates at ground potential, simplifying the problem of providing adequate x-ray protection by allowing the protection to be placed nearer the generating source, and permitting the use of tap water for cooling the target. Experience with the outfit indicates that other oil-immersed units can be built for much higher voltages with the same general design, without increasing volume or weight to excessive proportions or requiring special buildings for their installation. The over-all dimensions of the 500,000-volt outfit are 4 ft. wide, 4 ft. high, and 6 ft. long.

The 500,000-volt multi-section x-ray tube has a cathode, anode, and four intermediate electrodes. The insulating portion of the tube has an over-all length of 26 in. and a diameter of 3½ in. The extension chamber is built with a nickel tube 24 in. long and 2 in. in diameter. The tungsten target, backed by nickel, is at the end of the tube, outside the voltage insulating envelope. Compared with tubes for operation in air, the new tube is extremely small.

BOOK REVIEWS

DIRECTORY AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS. Paper; 135 pages; $5.00; American College of Hospital Administration, 18 East Division Street, Chicago.

The American College of Hospital Administrators has carefully collected the essential information regarding all those who have been admitted to fellowship and has published this in the form of a neat, paper-covered book.

CREATIVE CAMERA ART; Dr. Max Thorek, F. R. P. S., F. R. S. A. 156 pages. $3.75. Fomo Publishing Co., Canton, Ohio.

At the present time, when photography in the hospital, although still in its infancy, is being increasingly used, a work on the subject by a physician and hospital administrator who is also a world recognized leader in photographic art, is particularly timely. Doctor Thorek's publication is not only inspirational but also it is exceedingly practical.

The work in its first chapter deals with the development of photography. This is followed by a discussion of the general principles. The chapter on paraphernalia and methods of procedure is a statement of general principles. From this point the author becomes intensely practical. The chapter on exposure meters is highly technical; in some places, perhaps, too technical for the average reader. Yet, without a thorough knowledge of proper exposure the photographer can produce only accidental and haphazard results. Development, printing and fixing are discussed in a very thorough and understandable manner. A whole chapter deals with composition, that part of photography which is so important in any picture. Lack of knowledge of this particular feature is a fruitful source of failure.

Many other phases of the photographic art are discussed, but space forbids a complete review. On the whole, the work is one which is well worth many hours of study by any person who has ambition to be anything more than a snapshot artist.

EYE HAZARDS IN INDUSTRIAL OCCUPATIONS; Louis Resnick and Lewis H. Carris. 247 pages. Price 50c. National Society for the Prevention of Blindness, Inc., 50 West 50th Street, New York.

"Eye Hazards in Industrial Occupations" is a handbook for safety engineers, safety inspectors, safety committeemen, industrial physicians and nurses; for those responsible for industrial operations, whether owners, managers, or members of the operating staff; for governmental officials, trade association executives, and social agency officers; and for the many others who share the responsibilities and opportunities for conserving the life, health and sight of the millions of men, women and children employed in industry.

The volume contains 247 pages, and includes fifty-nine illustrations dealing with the safeguarding of eyesight in factories, mines, shops and offices. Orders or inquiries concerning this volume should be addressed to the National Society for the Prevention of Blindness. This book, which sold formerly at the actual cost price of $1.50, is now sold at 50 cents.

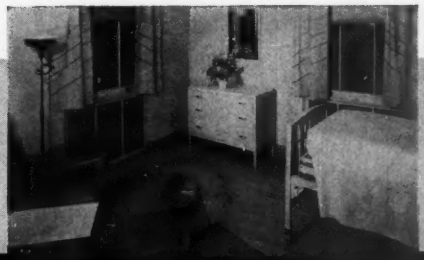
500 WAYS TO GET MORE FOR YOUR PAYROLL DOLLAR—J. O. & Crete Dahl. Cloth, 120 pages, $2.00; The Dahls, Haviland Road, Stamford, Conn.

Securing and management of employees is an increasingly difficult problem and the authors in this publication discuss the guiding principles in a comprehensive manner. While the work is directed chiefly to hotels, restaurants and clubs, it is equally applicable to hospitals.

HOW TO HANDLE GRIEVANCES—Glenn Gardiner. Paper, single copy $.45; leatherette, single copy $.60; 52 pages. Elliott Service Corporation, 219 East 44th Street, New York, N. Y.

Since the validation of the (Wagner) National Labor Relations Act, as never before, the spotlight has been focused upon the urgency of dealing with employee grievances in an intelligent and effective manner.

Hence the importance of the present book, "How to Handle Grievances" written as a guiding manual for all persons in supervisory authority, both in industry and business.



THE HOSPITAL HOUSEKEEPER

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Biltmore Hotel
Providence, R. I.

MRS. ALTA LA BELLE
Michael Reese Hospital
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West Jersey Homeopathic Hospital,
Camden, N. J.

MRS ALICE M. ELDRIDGE
Fairmont Hospital
San Leandro, Calif.

CONTRIBUTING EDITORS

FUEL CONSERVATION

By S. R. JENSEN
Chief Engineer, The University of Chicago, Member of A.S. M.E.

» » » IN THE FACE of rising coal prices and possibly an additional increase in freight rates, the question of fuel conservation is a very timely one. It therefore behooves every one to examine the heating system and see that all the avenues of waste are strictly guarded.

It is a sad fact, but true, that although the heating system is a major expense in the operation of a building yet from the standpoint of economy it is the equipment which receives the least attention.

The principles of fuel conservation are few and simple, and are applicable to all buildings, homes, offices or hospitals, whether the fuel is solid, gaseous or liquid, and when properly applied will yield gratifying results in reduced fuel costs.

It may be well to explain that the heating system consists of three major divisions:

A. The Boiler Plant, where the fuel is burned in order to generate steam or hot water.

B. The Distribution System, which may be either ducts carrying the hot air, or pipes carrying the steam or hot water to the heating equipment.

C. The Heating Equipment, consisting of radiators, coils or other equipment used in the building to heat the rooms.

The boiler plant may be a very efficient one where the fuel is burned with great economy. But the savings obtained in the boiler plant will be dissipated if the distributing pipes waste the heat on its way to the building, or the heating equipment in the building is not functioning properly. Or the building may be up to date in every respect, well designed, and with the very latest in automatic control and heating equipment giving excellent results in efficiency and economy of operation, and yet this saving may very often be swallowed up by a wasteful, run-down and obsolete boiler plant, with leaky, bare or scantily covered distributing pipes.

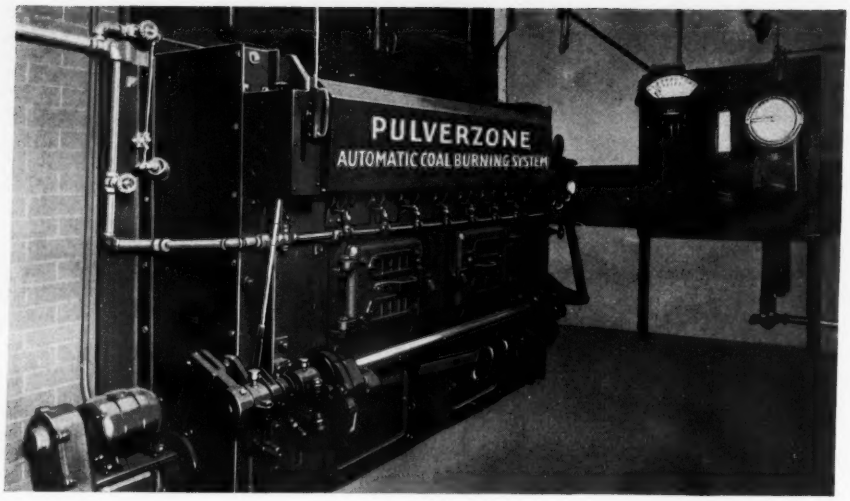
Each of these three divisions represents, therefore, a field in which to look for waste, and by coordinating the boiler plant, distributing system and the heating equipment, a real fuel conservation will be brought about.

It is necessary that each of these divisions be dwelt upon, and the ills usually encountered pointed out, and as a remedy state some general rules to follow in order to eliminate waste. We will therefore start with the heart of the heating system.

The Boiler Plant

As there are no two plants alike, each one must receive a careful study as there are many factors influencing the economical operation of a boiler plant. The first question is to ask yourself in entering the boiler room "Are we using the right kind of fuel?" If you are burning coal, the question is an all important one as there are a great many varieties of this fuel. It may be that the coal you are using is not suited to the existing plant equipment. Very often savings can be effected by using a coal of somewhat different characteristics. This does not necessarily mean a coal that costs less per ton. It simply means

Conducted in cooperation with The National Executive Housekeepers Association, Inc.



Instrument panel in the boiler room showing a gas analyzer (CO_2 machine), draft gauge and flue gas thermometer. Illustration courtesy of The Hays Corporation.

a coal which will produce the desired steam at a minimum cost.

In certain localities it may be well to look into the question of using either gas or oil for fuel, and here again the ultimate cost of steam is the criterion.

If coal is the fuel used we should be certain that we are getting what we pay for. The quality should remain uniform throughout its use. This may be checked by an occasional fuel analysis, and by weighing the coal when delivered to the boiler room, we would know that the quantity is correct.

It may be that the firing methods are obsolete, that by a small investment in proper firing equipment, savings in fuel, labor and steam costs can be effected along with a more satisfactory operation. This, however, would be a case for a competent engineer to decide.

As to maintenance, the most important general rule to follow in any plant is to bring the equipment into the best physical condition possible and keep it in this manner. Worn, damaged or defective parts never function properly nor are they conducive to efficiency and economy of operation.

Keeping the equipment in first class condition is also good insurance against a breakdown. A breakdown usually occurs at a time when the heating load is heaviest, and in the case of a hospital would be a very costly occurrence.

Furnaces should be free from slag and clinkers. Ashpits should be thoroughly cleaned and kept clean. Defective grate bars should be replaced. Cracks in the brickwork should be repaired so as to reduce air infiltration to a minimum. Soot and incrustations should be removed from the heat transmitting surfaces as frequently as is necessary.

The breeching and chimney should be kept thoroughly cleaned and all cracks and holes sealed up. Air filtration beyond the last heating surface, as in the breeching and the chimney, does not represent a loss in itself, but impairs the draft and in this manner indirectly affects the efficiency of combustion. Be sure that all baffles are tight so that the flames are not short circuited and carry the heat up the chimney, instead of imparting it to the heating surfaces. The water side of the heat transmitting surfaces should be freed from scale. This means that the condition of the boiler water should at all times be such that there are no scale-forming impurities present. All tubes, valves and fittings should be made tight against leakage. The boiler feed pump should have its share of inspection so that the "slippage" is within reason. All exposed surfaces of the boiler drums should be covered with a proper thickness of insulating material.

It is proper to include here the importance of keeping the boiler plant neat and clean. Cleanliness is always an index of efficiency in the boiler plant and every operator should therefore make it a matter of pride to keep the plant as clean and tidy as possible. The broom and mop are two of the most important tools in the boiler room.

There is another angle to cleanliness in a boiler room and that is the safety question and fire hazard. A place where waste, oily rags and refuse are permitted to accumulate is a potential fire hazard, and the operator who in his tidy boiler room keeps every tool and implement in its place is furthering the cause of accident prevention.

Next to the fuel, water is the most important commodity in the boiler plant. If your water bills are out of line, have the water meter checked periodically and make certain that the blow-off line is tight and that no water faucets are kept running.

Not so many years ago it was a poorly operated plant that could not produce a smoking chimney. The fireman was instructed to simply keep the pressure up to a predetermined point. His only guides were the water gauge glass on the boiler and the steam pressure gauge. Economy and efficiency were not included in the boiler room vocabulary, because fuel and labor were cheap.

Happily, this picture is now completely changed. With the increase in the fuel cost and cost of labor came the need for control equipment that would help the operator, and instruments that would tell him what he was doing, and what he could do, and at the same time provide a record of the performance. The instruments of today in a boiler plant are sturdy, reliable and moderately priced. They are within reach of the smallest plant and are investments that will give surprisingly high returns. A boiler equipped with a draft gauge, CO_2 machine, and thermometer registering the temperature of the exit gas, and operated by a man who knows how to make use of the information these instruments furnish, cannot help but

show efficiency and economy that will make for lower fuel bills.

One of the most common neglects in a boiler plant is the lack of keeping adequate and accurate records of performance and costs. Without records the operator has no yardstick with which to measure his success or failure, and is unable to compare the performance of his plant with that of his neighbor. A properly kept boiler room log, where operating data and costs are continually being checked, and made use of, can not help but reflect in lowered costs.

The Distributing System

All ducts carrying the heated air from the hot air furnace should be free from leaks. All joints should fit tight. In order to minimize the loss by radiation to surrounding space, the ducts should be covered with a suitable thickness of covering, particularly ducts near outside walls, cold water pipes and doors admitting cold air.

The pipes conveying steam or hot water to the heating equipment in the building should all be properly insulated unless the pipe is used for heating surface. To lengthen the life of the pipe covering and also improve appearance, the covered pipes should be given several coats of paint. It may be in order to warn against the painter applying paint to the stems and stuffing boxes on the valves, as this usually causes trouble the next time the valves are to be operated. All pipe joints should be tight. It is only human to delay fixing a leak because it may be inconvenient for the engineer to repair it when discovered. Even a small leak, permitting steam or hot water to escape, will in a short space of time waste a surprisingly large amount of money.

All lines should be provided with adequate means for air elimination. All steam lines should be properly trapped, and the engineer should be certain that all traps are functioning properly. It is always good economy to examine and repair, if necessary, every trap in the whole heating system before the heating season starts.

In a steam plant all condensate, if possible, should be returned to the boiler. This is advisable for three reasons:

1. The condensate is "soft" water and will cause no scale formation, with consequent loss of efficiency in the boiler.
2. If this condensate is not returned it represents a heat loss, as the condensate temperature is undoubtedly higher than that of the cold boiler make-up water.
3. If not returned it represents a monetary waste, if the make-up water is purchased.

Heating Equipment

When we say heat a building the fact is we heat the air in the building. In order to maintain certain uniform temperatures during occupancy a sufficient quantity of heat must be supplied to compensate for the constant dissipation or loss of heat. This heat loss is caused by the passage of air into and out of the building through cracks around windows, doors and skylights. It is therefore necessary to calk all door and window frames, weather strip all windows, repair all loose fitting windows and doors, and provide either revolving or vestibule doors.

Heat is also lost by conduction through the building materials and through glass. There is very little that can be done to decrease the loss through the building materials after the building is built, but the loss through glass which is by far the greatest, can be cut down by the installation of storm sashes, where it is not necessary to open and close the windows.

Wherever possible the radiation should be placed near the outside walls, preferably under the windows, and not obstructed. Open windows in a building always present a problem in heat conservation. As a rule they are not opened for ventilation but because the rooms are overheated. If it is necessary to have some ventilation in the room, the top sash should be pulled down.

It is a good policy to determine the required temperatures for the various rooms. The store rooms and shops can be carried at a much lower temperature than that of the office or library.

Properly maintained temperatures, along with proper humidity, provide healthier, more comfortable and more efficient working conditions. If the moisture content in the air is too low, as is generally the case during the heating season, a much higher room temperature must be maintained to provide a feeling of comfort than would be necessary under proper humidity conditions. The higher temperature results in increased heat losses. Humidity can be controlled by the use of water evaporating pans for the radiators, the conventional water jacket for warm air furnaces or the air washer type humidifier for fan heating systems.

It is also well to determine the hours that the heating is required during the day, so that the steam may be shut off for the maximum time at night, Sunday and holidays, and that only enough steam is on to prevent damage to plumbing by freezing in unoccupied sections of the building.

Whenever possible during the day steam should be turned off. During the year steam can be shut off 55 per cent of the total daytime. If parts of a building require long time or all night heating, it will be much more economical to run separate steam lines to these parts rather than heat the whole building.

It was stated above that we heat the air in the building. If we change the air twice every hour, the heat required will be twice as much as if we only change it once. In older buildings equipped with ventilating systems, we should carefully see that the heat is not wasted.

In buildings using hot water instead of steam the temperature of the water should be regulated in relation to the existing outside temperature.

In large buildings where forced hot water circulation is employed the temperature spread should be watched, that is the temperature difference between the outgoing and returned hot water, also the speed of the circulating pumps.

Here again, it is in order to say that the heating equipment should be maintained in the best physical condition. It is always good economy to inspect all of the equipment prior to the start of the heating season. It may be well to stress that special attention should be paid to all steam traps. If steam is purchased from a central station steam company, steam lost through a leaky trap represents a direct dollar loss, as steam that is paid for is permitted to escape without doing useful work.

In the temperate zone the ordinary heating equipment is designed to maintain 70° F. inside temperature when the

outside temperature is 0° F. This lowest temperature occurs actually during less than 5 per cent of the heating season, so that for 95 per cent of the season the heating equipment is required to operate at less than its designed capacity. It is therefore readily seen that unless the heat supply to a building is carefully controlled the fuel bill is apt to be much greater than it should be.

As the tendency is always to overheat rather than underheat and as the heat losses from a building vary with every change in outside temperature and wind velocity an "automatic heat control" should be provided that will adjust the heating to suit the weather conditions as well as occupancy of the building.

There are several methods of control. The one best suited will depend on the size and use of building, the type of heating equipment installed and the character of service desired.

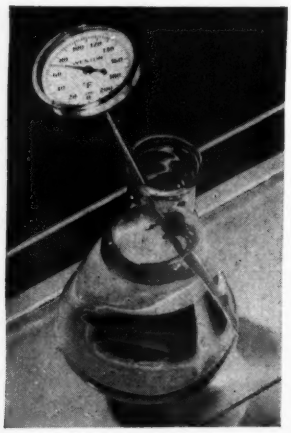
The heating equipment should be provided with necessary flow meters, recording gauges and instruments. They are of inestimable value to the engineer in the efficient and economic operation of the heating equipment. They are his silent sentinels and provide interesting and useful records.

The engineer should keep a daily log in which the records of steam consumption, temperatures, degree-days, wind velocities, etc. are kept.

The engineer very often blames "poor design" and "obsolete equipment" for high steam consumption and high operating costs. He may be correct in many cases, but it does not relieve him of the responsibility of operating the equipment in such a manner that the best results in fuel economy are obtained with his present equipment.

NEW EQUIPMENT

Stainless Steel Thermometer For Laboratory Use

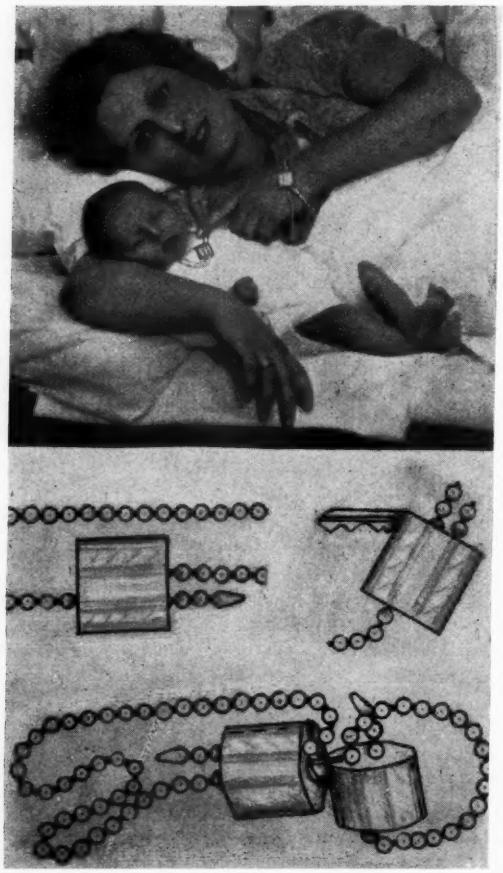


» » An entirely new type of laboratory thermometer, provided with a dial-and-pointer scale encased in stainless steel, mounted on top of an eight-inch stainless steel stem, is being introducted by the Weston Electrical Instrument Corporation of Newark, N. J.

The unit is said to be the first dial-type thermometer with an all-metal temperature element sufficiently accurate for scientific use. The pointer is actuated by means of an internally balanced double coil of thermostatic bimetal sealed in the lower 1½ inches of the seamless stem. When the stem is immersed to a depth of 1½ inches in a liquid (three inches in gas or vapor), the dial reads temperature values accurately without the necessity for stem correction.

Accuracy of the unit is guaranteed to ½ of 1 per cent over the entire scale. In practice, the location of the dial at the top of the stem, removed from the liquids or vapors under measurement, encourages a further increase in the accuracy with which readings are made. Dial markings are spaced for maximum readability on the metal scale plate, and are not subjected to obliteration from the solutions under test, as is the case with stem gradations. The low temperature values are not obscured in dark-colored or viscous solutions.

Ranson Interlocking Marking System



» » The Ransom Interlocking Marking System comprises two precision interlocking units, a non-interchangeable necklace for the baby and a wristband for the mother. Being sterilizable, they appear on the instrument tray in the white room. Application requires less than thirty seconds, and is made before the cord is severed.

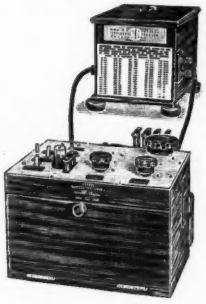
Each unit is a combination lock and each set is of a different combination. Sets are numbered from "one"

to whatever number is required for the number of bassinets.

It is fool-proof, because the operator must have the other unit of a set of the same number or neither element can be applied. It is infallible as neither element can be removed unless the same mother and baby are brought together again. The mother's element is used to set the baby's and the element set on the baby is used to set the mother's. Removal is made in the same manner.

The sets will be installed at no cost to the maternity, under a profitable contract. The sets are very small, gold elements, beautiful and accurate. The system is positive not only in normal cases, but is an identification proof in death or even in fire catastrophe and will logically reduce indemnity risks. Sets will be available about February 1, 1938. Manufactured by the Ranson Interlocking Marking System, Inc., Cleveland, Ohio.

Evelyn Photoelectric Colorimeter



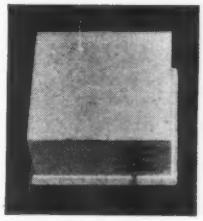
» » A single-cell direct-reading photoelectric photometer for increasing the accuracy, speed, and objectivity of colorimetric chemical analysis has been announced by the Rubicon Company, Philadelphia, Pa. Important features of the apparatus are: (1) the availability for use with the equipment of a complete series of stable light filters covering the entire range of the visible spectrum (2) permanency of the light filter characteristics due to their all-glass composition (3) stability of light intensity (4) utilization of convenient and inexpensive test tube type of absorption cells (5) standardization of the apparatus to facilitate the widespread adoption by all users of the equipment of constants carefully determined by a central laboratory when such constants cannot be conveniently determined by individual workers due to the rarity of the pure substance involved, or to other cause.

Steamatic Egg Cooker

» » The Hankscraft Company has recently announced a new automatic egg cooker, trade-named "The Steamatic". The new cooker is claimed to be easy to use, efficient and economical. Completely automatic, the unit starts cooking in five seconds and shuts off the current when the eggs are cooked. It plugs into any 115-volt A.C. lighting circuit.

The eggs may be cooked soft, medium or hard, the cooking time depending upon the amount of water used—one dipper for soft, two for medium and four for hard. To boil eggs: the eggs are placed in the tray and a measure of water added. The water starts the electric current and live, fresh steam cooks the eggs. Whe nthe eggs are done, the steam stops coming from the cover and the current shuts off automatically. There are no hot wire coils to burn out. To poach or scramble eggs: one or two eggs are broken into the poaching pan, and a measure or two of water poured in the steam bowl.

"Vitalaire"



» » The Lowell Air Conditioning Corporation of Philadelphia has developed an apparatus to which they have given the name "Vitalaire." A transformer changes the ordinary low voltage current into high potential which, when discharged, produces ozone. This is diffused into the surrounding air and it is claimed that the production and diffusion of ozone not only kills odors but actually purifies the air.

Oxygen Therapy Equipment. . .

(Continued from page 19)

letter to the J.A.M.A., Barach[9] described the almost total neglect of many physicians regarding this matter. In prescribing oxygen therapy the concentrations of oxygen desired should be specified, and during the treatment frequent tests of the oxygen concentrations should be made.

With the Binger type test board (Figure No. 7) a complete oxygen analysis can be made in one minute. A 10 cc. sample of gas is drawn into the burette from the tent and is then introduced into the oxygen absorption tube. After three quarters of a minute the unabsorbed gases are withdrawn from the absorption tube into the calibrated burette where the oxygen percentage can be read directly. No calculations are necessary.

Riseman recently developed a simpler type of test board (Figure No. 8) which is easier to operate than the Binger type but which, in the writer's opinion, is not as accurate and requires frequent adjustment by someone familiar with its construction. By means of these devices the necessary frequent check-up of oxygen concentrations in tents can be made easily and quickly.

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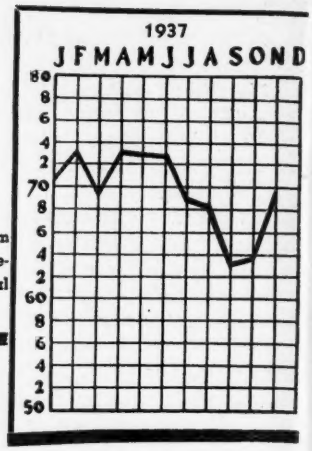
How's Business?

The charts and figures on this page are based on returns from 91 community type hospitals in 35 states. "Hospital Management" was the originator of this business chart of the hospital field. Watch it every month.



Total Daily Average Patient Census

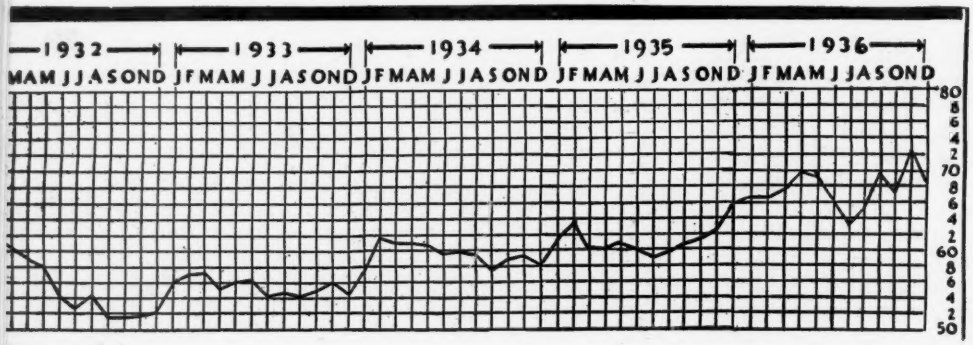
August, 1932	9,748
*September, 1932	9,125
*October, 1932	9,226
*November, 1932	9,328
December, 1932	9,403
January, 1933	10,037
February, 1933	10,197
March, 1933	10,222
April, 1933	9,955
May, 1933	10,004
June, 1933	10,023
July, 1933	9,786
August, 1933	9,809
September, 1933	9,716
October, 1933	9,883
November, 1933	10,003
December, 1933	9,787
January, 1934	10,358
February, 1934	11,074
March, 1934	11,013
April, 1934	10,993
May, 1934	10,869
June, 1934	10,638
July, 1934	10,701
August, 1934	10,620
September, 1934	10,309
October, 1934	10,524
November, 1934	**10,634**
December, 1934	10,378
January, 1935	11,062
February, 1935	11,426
March, 1935	10,731
April, 1935	10,858
May, 1935	10,946
June, 1935	10,802
July, 1935	10,662
August, 1935	10,765
September, 1935	10,738
October, 1935	10,989
November, 1935	11,079
December, 1935	11,324
January, 1936	11,414
February, 1936	11,408
March, 1936	11,463
April, 1936	11,894
May, 1936	11,304
June, 1936	10,547
July, 1936	9,863
August, 1936	10,004
September, 1936	10,137
October, 1936	9,454
November, 1936	10,204
December, 1936	9,687
January, 1937	10,771
February, 1937	10,941
March, 1937	10,990
April, 1937	11,703
May, 1937	11,002
June, 1937	11,403
July, 1937	10,914
August, 1937	10,712
September, 1937	9,805
October, 1937	10,004
November, 1937	11,590

Receipts from Patients

August, 1932	1,327,016.00
September, 1932	1,244,635.00
*October, 1932	1,248,504.00
*November, 1932	1,206,405.00
December, 1932	1,258,672.00
January, 1933	1,331,825.00
February, 1933	1,234,741.00
March, 1933	1,271,784.00
April, 1933	1,284,895.00
May, 1933	1,342,120.00
June, 1933	1,333,867.00
July, 1933	1,290,472.00
August, 1933	1,310,558.00
September, 1933	1,283,945.00
October, 1933	1,304,642.00
November, 1933	1,293,923.00
December, 1933	1,268,788.00
January, 1934	1,373,274.00
February, 1934	1,357,394.00
March, 1934	1,479,786.00
April, 1934	1,529,596.00
May, 1934	1,549,902.00
June, 1934	1,543,631.00
July, 1934	1,495,036.00
August, 1934	1,469,074.00
September, 1934	1,412,009.00
October, 1934	1,537,002.00
November, 1934	**1,520,135.00**
December, 1934	1,446,092.00
January, 1935	1,506,382.00
February, 1935	1,562,412.00
March, 1935	1,563,621.00
April, 1935	1,536,286.00
May, 1935	1,565,526.76
June, 1935	**1,528,129.00**
July, 1935	1,514,901.00
August, 1935	1,522,877.00
September, 1935	1,516,305.00
October, 1935	1,534,179.00
November, 1935	1,546,341.00
December, 1935	1,552,421.00
January, 1936	1,561,623.00
February, 1936	1,559,611.00
March, 1936	1,612,982.00
April, 1936	1,915,277.00
May, 1936	1,536,408.00
June, 1936	1,657,474.00
July, 1936	1,490,688.00
August, 1936	1,535,688.00
September, 1936	1,457,640.00
October, 1936	1,520,719.21
November, 1936	1,465,067.52
December, 1936	1,272,765.60
January, 1937	1,539,576.00
February, 1937	1,516,917.60
March, 1937	1,672,002.72
April, 1937	1,694,262.24
May, 1937	**1,776,046.32**
June, 1937	1,646,881.92
July, 1937	1,728,112.32
August, 1937	1,773,724.32
September, 1937	1,496,919.68
October, 1937	1,679,252.40
November, 1937	1,624,680.72

Operating Expenditures

August, 1932	1,565,767.00
*September, 1932	1,508,519.00
*October, 1932	1,515,582.00
*November, 1932	1,488,989.00
December, 1932	1,568,845.00
January, 1933	1,546,747.00
February, 1933	1,490,075.00
March, 1933	1,585,755.00
April, 1933	1,531,870.00
May, 1933	1,536,710.00
June, 1933	1,545,307.00
July, 1933	1,555,554.00
August, 1933	1,555,701.00
September, 1933	1,579,869.00
October, 1933	1,611,151.00
November, 1933	1,620,478.00
December, 1933	1,651,676.00
January, 1934	1,680,330.00
February, 1934	1,648,750.00
March, 1934	1,716,400.00
April, 1934	1,723,237.00
May, 1934	1,763,407.00
June, 1934	1,757,885.00
July, 1934	1,800,817.00
August, 1934	1,782,184.00
September, 1934	1,770,998.00
October, 1934	1,815,650.00
November, 1934	1,830,598.00
December, 1934	1,846,180.00
January, 1935	1,883,938.00
February, 1935	1,888,570.00
March, 1935	1,773,343.00
April, 1935	1,813,947.00
May, 1935	1,826,149.93
June, 1935	**1,810,623.00**
July, 1935	1,736,856.00
August, 1935	1,795,539.00
September, 1935	1,828,619.00
October, 1935	1,831,115.00
November, 1935	1,849,120.00
December, 1935	1,897,615.00
January, 1936	1,934,852.00
February, 1936	1,929,623.00
March, 1936	1,954,182.00
April, 1936	1,897,523.00
May, 1936	1,871,964.00
June, 1936	1,921,027.68
July, 1936	1,689,696.00
August, 1936	1,847,736.00
September, 1936	1,896,120.00
October, 1936	1,918,931.76
November, 1936	1,817,101.44
December, 1936	1,568,264.40
January, 1937	1,864,748.16
February, 1937	1,890,667.44
March, 1937	1,969,652.16
April, 1937	2,180,839.60
May, 1937	1,988,845.92
June, 1937	1,990,221.12
July, 1937	1,933,971.84
August, 1937	2,066,890.32
September, 1937	2,058,107.72
October, 1937	2,140,030.08
November, 1937	1,958,306.24



Average Occupancy on 100 Per Cent Basis

July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.7
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6
*November, 1932	52.2
December, 1932	52.6
January, 1933	56.2
February, 1933	57.0
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9
September, 1933	54.4
October, 1933	55.3
November, 1933	56.0
December, 1933	54.7
January 1934	57.9
February, 1934	62.0
March, 1934	61.6
April, 1934	61.5
May, 1934	60.8
June, 1934	59.5
July, 1934	59.9
August, 1934	59.4
September, 1934	57.7
October, 1934	58.9
November, 1934	**59.5**
December, 1934	58.1
January, 1935	61.9
February, 1935	63.96
March, 1935	60.07
April, 1935	60.78
May, 1935	61.09
June, 1935	**60.02**
July, 1935	58.6
August, 1935	59.8
September, 1935	60.1
October, 1935	61.4
November, 1935	62.1
December, 1935	65.8
January, 1936	66.2
February, 1936	66.18
March, 1936	67.6
April, 1936	70.0
May, 1936	69.1
June, 1936	66.3
July, 1936	63.9
August, 1936	65.7
September, 1936	70.0
October, 1936	67.1
November, 1936	72.5
December, 1936	68.8
January, 1937	70.9
February, 1937	73.05
March, 1937	69.98
April, 1937	73.0
May, 1937	72.48
June, 1937	72.35
July, 1937	68.58
August, 1937	68.05
September, 1937	63.25
October, 1937	63.09
November, 1937	69.8

*One hospital closed during construction program